Washington State Planning Grant on Access to Health Insurance

Mount Rainier National Park

HRSA Progress Report

March 2002

Making Health Care Work For Everyone

Project funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration's Bureau of Professions State Planning Grant #1 P09 OA 00002-01

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Project Staff

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The Foundation for Health Care Quality

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WASHINGTON STATE
HRSA STATE PLANNING GRANT ON ACCESS TO HEALTH INSURANCE
REPORT TO THE SECRETARY: OVERVIEW OF PROGRESS AS OF MARCH 2002

EXECUTIVE SUMMARY

Washington State received its grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) effective March 2001. States were awarded these grants to assist them in profiling the uninsured and to research options for providing access to affordable health insurance coverage, especially through expanded private/public partnerships.

Following the pattern of most other states that received these one-year grants, Washington State applied for and received an extension beyond March 2002. At this point we anticipate continuing our work for several months. This report constitutes our second progress report to HRSA (the first was submitted in October 2001), with a final report due at the end of the revised grant period.

In the following sections of this Executive Summary we describe: (1) the context for the grant work, (2) project goals, (3) draft findings, (4) changing environment, (5) federal recommendations, (6) next steps, and (7) the remainder of the report.

To get the inevitable out of the way, we will say it right up-front. Our work confirms conventional wisdom: IT is about money and values**.** Now, for the rest of our work:

Context

The focus of our work is quite specific, it is about health insurance – who has it and who doesn't, why, and what to do about it. The focus stems from the practical reality of the grant requirements (i.e., profile the uninsured and explore options to improve access to insurance coverage) as well as the "human" reality that insurance coverage does matter. A growing body of literature supports the notion that although insurance doesn't guarantee access to care it is still an important vehicle.[1] For example, compared to the insured:[2]

[1] A recent Seattle Times article illustrates the point that insurance coverage is not synonymous with access to care. The article describes the growing number of Washington clinics that is turning away Medicare and Medicaid clients. *Seattle Times*, Tuesday, March 12, 2002. (Perhaps we need to ensure that our definition of insurance coverage includes adequate access to providers!)

[2] Sample sources for this information include: *Coverage Matters, Insurance and Health Care*, Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine, 2001; *No Health Insurance? It's Enough to Make You Sick – Scientific Research Linking the Lack of Health Coverage to Poor Health*, American College of Physicians, American Society of Internal Medicine, 2000; and, Prospects for Expanding Health Insurance Coverage, *New England Journal of Medicine*, Vol. 344, No. 11, March 15, 2001.

The uninsured have reduced access to health care (process measure), they are:

- Less likely to have a regular source of care
- Less likely to have had a recent physician visit
- Less likely to use preventive services
- Less likely to receive follow-up care after hospital discharge
- More likely to delay seeking care
- More likely to report they have not received needed care
- More likely to use a pharmacist than physician for medical triage

The uninsured have poorer medical outcomes & lower quality of life (outcome measure):

- Higher mortality in general and higher in-hospital mortality in particular (e.g., up to 3X more likely to die in-hospital)
- More likely to experience adverse health outcomes, e.g., more likely to be diagnosed with cancer at a late stage with lower survival rates (colon, melanoma, breast, prostate)
    - Women w/ breast cancer: 49% higher adjusted risk of death
    - Pregnant women: 31% higher likelihood of adverse hospital outcome
    - Chronic back pain: Much less likely (2.7X) to get back to work quickly
- More likely to require emergency hospital care and have avoidable hospitalizations, e.g., diabetes, hypertension, pneumonia, bleeding ulcers, asthma
- Less likely to undergo certain high cost or discretionary procedures, e.g., coronary bypass surgery, total hip replacement
- For women: More likely to be at higher risk of cardiovascular disease

Project Goals

Although the wording of the project's goals has morphed over time, their essence has not changed.

- Understand the characteristics of Washington's uninsured population, specifically around individual and family ability to afford coverage.
- Assess policy options for improving access to coverage in light of the above knowledge, specifically options that "learn from" Washington's history, build on private/public partnerships, and are community-based.
- Explore opportunities for creating a more affordable and user-friendly system via administrative simplification (e.g., reduce the "hassle" factor for providers and consumers).

To help accomplish the above we have, so far:

- Worked with a consultant team,
- Received guidance from a management oversight panel,
- Created a set of guiding principles,
- Sought targeted input on specific issues,
- Participated in others' related efforts, and
- Tried to stay relevant to the changing environment.

Draft Findings

We divided our work into two phases: (1) background research and (2) public vetting of findings. We are just wrapping up the former, and preparing for the latter. To-date, much of our work has been quietly occurring behind the scenes.

The consultant team recently completed the project's initial research phase. Their work is contained in the following draft deliverables.

- *Data for Assessing Access to Health Insurance Coverage in Washington State.* This report provides an assessment of data available for developing a comprehensive understanding of the characteristics and circumstances of Washington State residents without adequate health insurance coverage. The focus of the report is on survey data (population-based and employer-based). The report concludes with specific recommendations for: (1) which current survey data sources Washington should use, (2) how gaps in the data can be filled in the near term, and (3) what longer-term steps Washington can take to meet its future needs for survey data.
- *Profiles of the Uninsured: Targeting the Uninsured in Washington State, and Income Adequacy & the Affordability of Health Insurance in Washington State.* This report examines patterns of insurance coverage and characteristics of the uninsured population in Washington in order to identify groups for targeted interventions. The report also examines the potential effect of public program expansions in improving access for the uninsured and identifies populations that might benefit from measures to strengthen private insurance markets. Finally, the report tackles the issue of individual affordability from two perspectives: (1) likelihood of access to affordable coverage, and (2) level of income needed for specific family types, of varying health statuses, living in different regions of the state, to afford to buy coverage after paying for other basic living expenses.
- *Potential Policy Options for Enhancing Access to Health Insurance Coverage.* This report is done as a briefing book intended to inform discussions and decisions about how the state of Washington could best improve access to health insurance coverage and health services. A variety of policy options is explained and assessed in terms of our knowledge about the uninsured population.

With the understanding that these deliverables are still draft and under review by the State Planning Grant project team (and thus are not ready for public release), following are some key findings and messages about Washington's uninsured population and implications for addressing their lack of coverage. As we have time to "live with", and receive public input and reaction to, these findings we will be better able to appreciate their interconnectedness and complexities.

Table ES-1: Potential Implications of Select Draft Findings
Washington State Planning Grant on Access to Health Insurance

Draft Finding	Potential Implication
The majority of the uninsured have one or more of these general characteristics: low-income individual, single adult with no children, lives in a family with workers where the workers often do not have access to health insurance, has been uninsured for at least a year. For children in particular, some key characteristics of being uninsured are one or more of the following: having an uninsured parent, being in a low-income family, being in a family headed by a single female, being an older child.	This complex mix of characteristics reinforces the notion that in a world of incremental approaches no single strategy will do -- to achieve coverage for the remaining uninsured will require multiple approaches that are complementary and integrated.
Majorities tell only part of the story. There are pockets of major disparities in rates of un-insurance, such as for American Indians/Alaska Natives and Hispanics, and for various rural parts of the state compared to more urban areas.	Outreach efforts directed at underserved populations may be effective. Community-based models directed at linking providers and allied health professionals in order to provide team-based care to targeted populations may be effective in rural regions.
For many people being uninsured is transitory, i.e., many periods without coverage are short-term or transitional. However, most uninsured have long spells of no coverage (over a year).	Policies to fill short-term gaps such as helping those who have recently lost insurance could help a substantial number of people. However, since most uninsured have long spells of no coverage, these policies may not substantially reduce the overall uninsured rate.
The uninsured are primarily low-income, and the low income are much more likely to be uninsured than higher income families Family income is one of the key factors in the uninsured rate – it persists even when controlling for other characteristics that affect the likelihood of being uninsured.	Policies that focus on making coverage options (public and private) affordable for the low-income may help address this key barrier to insurance. However, not all barriers to coverage may be financial given that not all of the uninsured participate in programs for which they are eligible even when there is space available.
Children are the group least likely to be uninsured; still there is a significant number of uninsured children, the majority of whom are school age.	Most of these children are already eligible for public insurance programs. Strategies to close this gap therefore would entail outreach rather than eligibility changes, e.g., through schools.
Insurance status of the parent is a key predictor of the insurance status of children. Very simply, insured parents tend to have insured children and similarly, uninsured parents often have uninsured children. Where families make choices about which children to insure, they usually insure the youngest and the least healthy children. (However, most uninsured children are in families where all children are uninsured.)	Policies to insure adults and expand coverage for families may be effective in reducing the number of uninsured children.
About half of uninsured adults do not have access to affordable coverage in either the private or public markets – the rate is higher for uninsured adults with no children and is substantially higher for low-	Subsidies (and places to use those subsidies) may help this group. However, the subsidies would have to be fairly large (e.g., a 50% premium subsidy for low income uninsured buying on the private market

Draft Finding	Potential Implication
income adults. (The group most likely to be uninsured and that has the worst access to public or private insurance is adults without children.)	would likely have only modest effects). The experience of successful public subsidy programs (e.g., Basic Health) can be used to inform decisions about subsidy levels needed to support private sector purchasing by low-income individuals and families (as well as to assess the value of subsidizing public compared to private coverage).
The vast majority of the uninsured are workers or their dependents, i.e., they live in families with at least one employed person.	Policies to expand the private employer-based system may be a way to bring these people into the private insurance system. However targeting this population through the employer system is complex, e.g., most workers and dependents with access to coverage through an employer are already insured (even if low-income); many low-wage workers work for small, low wage businesses that do not offer coverage but not all do; although small, low-wage businesses are less likely to offer coverage, many do so; some workers may be less likely to accept coverage when offered so subsidies to employers to increase "offer rates" may not increase "acceptance rates".
Many of the uninsured are self-employed people or their dependents, in spite of the fact that federal tax subsidies are available to this group. (Uninsured rates in this group are not strongly related to income.)	Policies aimed at financial subsidies may or may not be of help in addressing the lack of insurance in this group. (The insurance deduction for self-employed persons is scheduled to increase to 100% by 2003 so this picture may change.)
About one-half of the uninsured without a current job recently lost work or is currently looking for work.	Policies to reduce the cost of transitional coverage might benefit this population.
Premium prices are related to whether coverage is offered by small businesses.	Policies creating premium subsidies could have some effect in increasing the percent of small employers offering insurance.
Characteristics of employers' workers are also associated with lower "employer offer" rates – these include having high proportions of one or more of the following: low-wage, young, female, or part-time/temporary workers.	Policies that focus only on the supply side, e.g., subsidies to encourage employers to offer coverage, may not have the intended effect (at least to the same degree as anticipated).

As indicated above, we have begun the process of tying the profile results to possible options or strategies for improving access to coverage for uninsured individuals and families.[3] Listed in the table below are categories of options, with prototypical examples, that have been explored for us by the consultant team and may hold promise for addressing gaps in coverage.

[3] Important to this analysis is the boost in credibility from using state-specific data that speak to the characteristics of our very own friends and neighbors; this presents a nice contrast to the ease with which national data are often discounted as not truly reflecting local conditions. Also important in this analysis is (1) the consultant team's creative linking of individual observations across population-based and employer-based surveys and (2) their application of bivariate and multivariate methods to highlight specific groups and their characteristics and to identify underlying causes of uninsurance (e.g., using methods so we can understand the independent effect of a characteristic after controlling for its relationship with other characteristics that affect the likelihood of being uninsured).

Table ES-2: Snap-Shot of Coverage and Access Categories for Research
Washington State Planning Grant on Access to Health Insurance

Major Grouping	Examples of Sub-Groupings Examined
I. Financial incentives to individuals and families to purchase health insurance (Subsidies include vouchers, tax credits, and direct payments)	• Subsidies to assist low income in buying individual coverage • Subsidies to assist high-risk people in buying individual coverage • Subsidies or reforms for transitional coverage (e.g. COBRA) • Subsidies of employee contributions to employer-sponsored insurance
II. Financial incentives to employers to purchase health insurance for their employees	• Direct subsidies or tax credits to employers • Play or pay mandate on employers
III. Health insurance purchasing pools	• Employer-based purchasing pools • Individual or individual/small market purchasing pools • Other community-based purchasing pools • Mobile worker purchaser pools • Consolidated state funded pools
IV. Insurance market regulations	• Relief from benefit mandates • Individual and small-group market regulations • High-risk pool expansion • Universal catastrophic coverage
V. Direct subsidies for safety net or charity care services (for those whom insurance may never seem like a viable option)	• Expand state's Community Health Services grant program • Create discount health cards for individuals • Expand federal health professional shortage areas (HPSAs) • Expedite Rural Health Center designation • Increase payment to providers via health plan contracts • Tax credit for not-for-profit hospitals • Tax credit for physicians, physician assistants, and nurse practitioners • Uncompensated care pools
VI. Public Insurance Program Expansions	• Although expansions of public insurance programs are included in our planning work, the consultant team did not address this category of options in their background research. Please see the footnote below for details.[4]

The goal of the research phase was not to "put on or take off the table" any particular options. We hope as this phase winds down that we have developed useful background information to stimulate discussions among the general public and delegated decision makers about Washington's future approaches to covering its residents.

[4] Expansions of public insurance are considered by many in the national policy community to be a viable, often preferable, approach to extending coverage to the non-elderly, low-income uninsured. The most commonly discussed options include: (1) attain full enrollment of all currently eligible individuals into existing public programs, (2) expand eligibility for children by raising the income eligibility level, and (3) extend coverage for adults – first focusing on parents of eligible children and then on adults without children. At the direction of the grant staff, the consultant team did not include public program expansions in their background work. This directive does not reflect a value judgment regarding the worth of public options, rather it reflects a practical reality on several levels: (1) focusing consultant resources where they were most needed, (2) recognizing that Washington has already taken steps (e.g., covering children up to 250 percent of federal poverty) or is currently taking steps (e.g., refining a Medicaid waiver that includes coverage of some adults) related to public programs, and (3) the grant's interest in private/public partnerships (including but not solely focused on public programs) for their intrinsic value but also in light of state budget challenges.

Changing Environment

The context for our work has changed significantly since Washington submitted its grant proposal in July 2000. A State budget surplus gave way to a deficit of $1.6 billion (or 7% of the budget) for the current biennium (July 01–June 03), with an equally fearful outlook for the next biennium. Cuts in services and programs just finalized by the Legislature are significant. Health care services, representing the second largest and fastest growing portion of the total state budget, have not been spared from sharing in the budget pain. For example, state-funded "Medicaid" coverage for 27,000 legal immigrants will be eliminated and "replaced" with an opportunity for these adults and children to buy state subsidized Basic Health coverage. Given this environment, the original grant vision of identifying expansion opportunities has been greatly tempered, at least for the short-term.

However, the future is not all bleak. There are on-going efforts to continue "the dialogue" as well as new efforts on the horizon.[5] For example, the Governor and the independently elected Insurance Commissioner are exploring the formation of a jointly chaired health care council. The focus of this council, if created, will be broader than access to coverage for the uninsured but will nonetheless include that issue.

We continue to examine and refine our work based on this changing environment, with the hope that it can both stimulate and provide a foundation for future discussions.

Federal Recommendations

In the body of the report are several recommendations to the federal government that have arisen during the course of the last year. Of particular interest are:

- Federal support for periodic and longitudinal state-specific data collection efforts – both population-based and employer-based – that allow analyses at relevant sub-state levels.
- Federal support for policy and planning efforts – during the tight economic times facing many states there is precious little money to meet priority needs for services, with little (if any) left over for future planning efforts.
- Full funding of federal obligations, e.g., Medicare prescription drug coverage, Indian Health Services.
- Additional federal flexibility in the Medicaid program, with HIFA (Health Insurance Flexibility and Accountability) as a good start but not sufficient. Also desirable is decreased reliance on "maintenance of effort" requirements and increased use of higher matching rates as incentives for covering additional populations (especially through use of the funds for leveraging private dollars).

[5] It is impossible to name all of the organizations and parties that continue to work on health care and access issues in Washington but they are many and varied, ranging from small groups in local communities to broad-based, state-domiciled, foundations and institutes.

Next Steps

As stated earlier, we divided our work into two phases. The first phase, i.e., initial research, is coming to an end. Shortly, it will be time to share, discuss, refine, and build-on this initial research with interested individuals and organizations. In keeping with our guiding principles we anticipate a fairly low-key approach – one that allows varied avenues for reaction and input. We will (1) use our website, (2) contact specific parties for small face-to-face meetings, (3) make our work and ourselves available to existing efforts, and (4) perhaps hold regional "get-togethers" for reflection and stimulation of dialogue. We hope not only to "create demand" for our work, but also to be responsive to existing needs for information. In addition, the following are a few things we hope to address in the upcoming months:

- Based on public input, we anticipate refining the quantitative analyses regarding impacts of specific policy options and perhaps "market testing" a smaller subset of options with specific groups (e.g., meeting with small business employers and employees to assess the value they place on various premium assistance options).
- We will continue our efforts to build partnerships related to coverage and administrative simplification strategies. For example, we are currently working with communities in the state (with technical assistance from the State Coverage Initiatives Program of the Robert Wood Johnson Foundation) to explore the design and feasibility of a community-based coverage and purchasing pool. In addition, we will work to respond to a recurring theme from our inventories (administrative simplification and community initiatives), i.e., external parties' frustrations in trying to partner with the state when it does not speak with a single voice and is often internally uncoordinated and unaligned.
- Our work on better understanding individual and family ability to afford coverage will continue. Ensuring that our complex results have broad practical utility for existing public programs and their potential redesign efforts is a high priority. We have an excellent start but additional work is needed (e.g., can a simple simulation model be developed based on our results that would allow program managers to assess impacts under various "what if" scenarios?).
- Also needed is additional thinking about how to qualitatively "trend forward" the profiling results and their implications. For a variety of reasons Washington was particularly interested in the degree to which it could use existing, state-specific, data to tell the story of its uninsured population. To a large extent this worked quite well, nonetheless, existing data by their very nature tell yesterday's story.
- Our profile results have strengthened interest in better understanding the values and trade-offs that drive people with similar life circumstances and characteristics to make very different choices in terms of electing or not electing to have insurance coverage. Although we have begun the conceptual work to address this issue, it is unlikely we will be able to fully pursue it within the current grant.
- Finally, a critical last step for us lies in finding a home for the work of the grant and in identifying leaders that will keep the work moving forward after this grant is completed.

Remainder of the Report

The body of the report is divided into eight sections, following the template provided by HRSA. The first three sections address the relationships between health insurance status and the characteristics of individuals, employers, and the marketplace, respectively. In Section 4 we focus on the range of options for addressing access to insurance coverage. Section 5 covers information on consensus building. The focus in Sections 6 and 7 is on recommendations to other states and to the federal government, respectively. Finally, Section 8 covers findings and recommendations regarding "best-practice" data sources and approaches for understanding the characteristics and circumstances of Washington's uninsured.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

Analytic Focus:

The goal of Washington's analysis of its uninsured population was to build upon previous descriptive efforts to obtain a comprehensive understanding of the characteristics and circumstances of residents without access to adequate coverage. Analysis focused on:

a. Identifying the best sources of available data to establish a consistent foundation for analysis of the population and to develop strategies for filling the gaps in data needed;

b. Broad and varied profiles of the population, designed to provide an in-depth picture of sub-populations for whom adequate access to coverage and care will require targeted interventions; and

c. Gaps, overlaps and barriers to coverage and care that emerge from the linking of population profiles with the mapping of available pathways to coverage and the current safety-net.

Methods:

a. Sources of data have been compiled, summarized, and analyzed to define data available and needed to complete the grant's work. Details on the state's data collection strategy are captured in Section 8. (Although this was not a specific requirement of the HRSA report, we believe that our consultant's analysis of existing data sources sets the stage for innovative linking of data across sources to profile our population and examine the underlying causes of uninsurance. In addition, information about reasons for differences in estimates across survey sources continues to provide helpful grounding for conversations about which numbers reflect the "true" size of Washington's uninsured population.)

b. Profiling analyses were based primarily on data collected in the 2000 Washington State Population Survey (2000 WSPS) however we have remained flexible and adapted our analytic approach (i) to respond to data gaps uncovered through our data analysis and (ii) to explore deeper and more policy-relevant characteristics of the uninsured population as the work evolved. To varying degrees, profiling analyses occurred along several dimensions that identify where and with what populations targeted interventions might be most effective.

   (i) profiling by demographics,

   (ii) comparison of bivariate and multivariate analyses to highlight the underlying causes of uninsurance. (Unadjusted numbers from the bivariate analyses provide the actual proportion of a group with a particular characteristic that is uninsured and therefore highlight the largest groups of uninsured individuals. Adjusted numbers (derived from the multivariate analyses) provide a measure of the importance of the characteristic in explaining the lack of insurance because they remove differences in uninsured rates associated with other factors.)

   (iii) profiling by family characteristics and circumstances,

   (iv) profiling by duration of uninsurance – long term, episodic and at-risk of losing coverage,

(v) profiling by employment and employer status (see Section 2)

(vi) profiling by availability, access and affordability of public and private coverage.

To a limited degree we have also worked on an approach that backs into target populations by linking potential coverage options to the populations for which they were designed and by evaluating the degree to which these populations are represented among Washington's uninsured.

c. As described in Section 8, constructs important for these (and other) analyses were not all available in the 2000 WSPS. Our consultant team therefore applied technically elegant approaches to fill key data gaps, imputing and synthetically attaching needed characteristics from (i) the 1998 WSPS (for a measure of any period of uninsurance during the year); (ii) the 1997 RWJF Washington Family Health Insurance Survey (for a measure of the length of the uninsurance spell in progress); and (iii) the 1997 RWJF Employer Health Insurance Survey (for detailed information about the offer of employer health insurance). Details of these techniques are described in Appendix III, Section 8, Methodology for Developing Key Data Constructs Not in WSPS.

d. Opportunities for future research have percolated from our preliminary analysis of current findings. For example, we continue to be interested in understanding the values and trade-offs that drive individual and family decision-making strategies to elect or not-elect coverage. As a companion to our affordability analysis we are looking at opportunities to go the next step in gathering evidence about the real differences in decision drivers of individuals and families with similar life circumstances and characteristics. For example, a "matched-sample" analysis of individuals that enroll in Basic Health compared with individuals with similar life circumstances and demographic characteristics, may offer promising insights for the crafting of future coverage and access strategies.

e. Economists report that Washington's current economic recovery lags behind the nation and the state faces further job losses within the aerospace industry and all government sectors at a minimum. A January 2002 Kaiser Family Foundation publication [i] "shows that rising unemployment will likely lead to a substantial increase in the number of uninsured." (In January 2002 Washington had the second highest unemployment rate in the nation.) Implications for revising profiles of Washington's uninsured are still to be determined. The next biennial survey of Washington's population, the 2002 Washington State Population Survey, is in the field now and results will begin to emerge later this year. It would be ideal to replicate the RAND Employer Health Insurance Survey and link results with WSPS 2002 (using the grant project's methodology) to provide more recent data that reflects current economic impacts.

Findings:

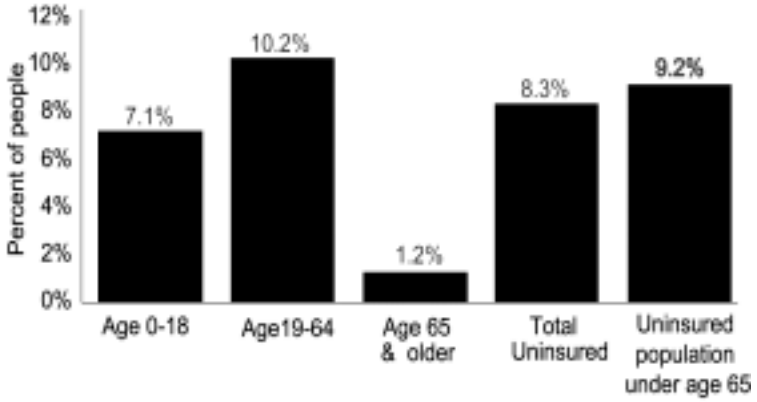
The following findings cover the basic profile of Washington's uninsured and reflect key points from the consultant team's analysis. The order of presentation matches the format requested by the funding agency, Health Resources and Services Administration.

While findings are consistent with those in national studies and in other State Planning Grant research states, this is by no means an exhaustive set. We have yet to fully reflect upon and refine findings to completely appreciate the important differences in groups that represent a critical mass of uninsured individuals and groups that represent disparities in access. With this

insight we will then be ready for the broad stakeholder and public input needed to help prioritize populations to target.

a. Overview of Uninsurance in Washington

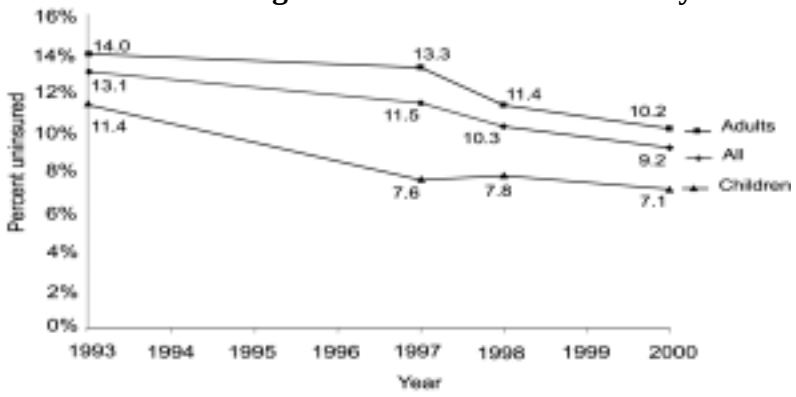
Percent Uninsured by Age, 2000



Source: 2000 Washington State Population Survey

In 2000, of a total population approaching 6 million, 8.3 percent of Washingtonians were uninsured. Most individuals over age 65 are covered by Medicare and some receive additional coverage through employer or public programs. Given almost universal coverage for this group, their major issues revolve around scope of benefits (and more recently, access to providers) rather than the presence or absence of health insurance. Consequently, unless otherwise noted, the following analyses of Washington's uninsured population focus on the under-age 65 population, where risk of being uninsured is greatest. In 2000, approximately 484,000 people under age 65 were uninsured.

1993-2000: Washington's Insurance Success Story



Source: 1993, 1997, RWJF Washington Family Health Insurance Survey;
1998, 2000, Washington State Population Survey. Data refer to the under 65 population.

During the 1990s, the uninsured rate in Washington declined steadily for adults and children. Surveys spanning the 1993-2000 period indicate that the uninsured rate for adults aged 19 to 64 dropped from 14.0 percent in 1993 to 10.2 percent in 2000. For children, the uninsured rate dropped from 11.4 percent to 7.1 percent over this period.

Sources of Insurance Coverage, 1993 to 2000

	1993	1997	1998	2000
Employment-based	70.9	68.8	68.0	70.7
Public	8.9	12.5	13.3	13.7
Individual	7.1	7.2	8.4	6.4
Uninsured	13.1	11.5	10.3	9.2

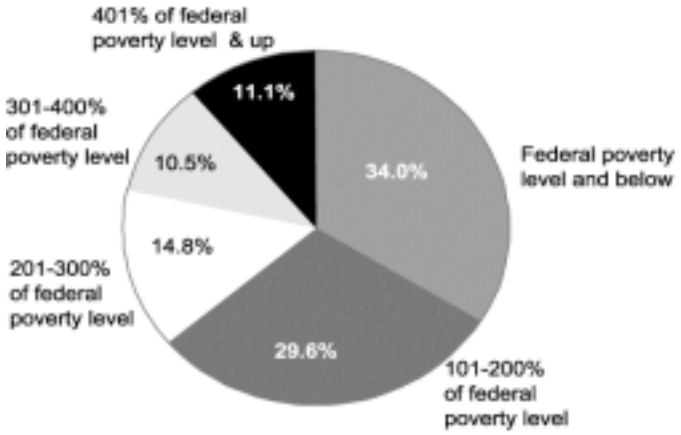
Source: 1993, 1997, RWJF Washington Family Health Insurance Survey; 1998, 2000, Washington State Population Survey. Data refer to the under 65 population

A major factor in this declining rate has been the expanding role of public insurance. During the 1993-2000 period, public insurance increased its role, while employment-based insurance remained stable, resulting in an overall decline in the proportion of uninsured. In the context of a State budget deficit for the current biennium and an equally solemn forecast for the next biennium, impacted by unemployment increases and general economic recession, the proportion of uninsured can be expected to rise.

b. Characteristics of Washington's Uninsured

Focusing on the largest sub-groups does not tell the story of populations who are disproportionately uninsured, or for whom and to what degree uninsurance is a long-term or episodic (i.e., transitional) event. We believe that understanding the underlying causes of uninsurance, i.e., the systemic barriers to coverage, is key to getting the potential coverage strategies correctly linked with the uninsured populations for whom they can be most efficient and effective. Our analysis looks beneath the demographic picture and begins to identify these underlying factors.

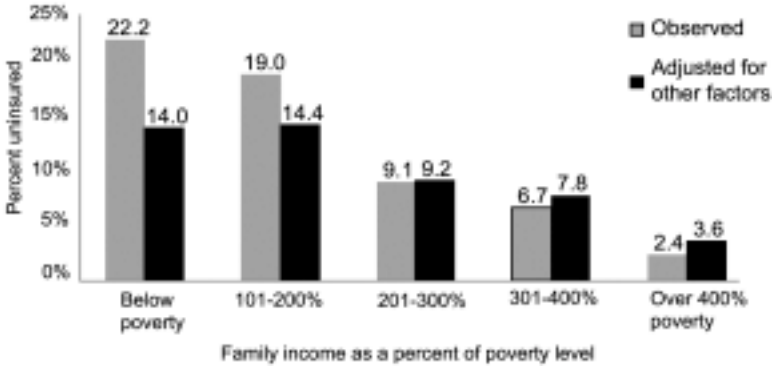
Distribution of the Uninsured by Income, 2000



Source: 2000 Washington State Population Survey
Data refer to the under 65 population

Family income is a persistent underlying factor in the uninsurance rate. In 2000, almost two-thirds of the uninsured under the age of 65 were in families with income levels below 200 percent of the federal poverty level ($34,100 for a family of four in 2000.) More than three-quarters of the uninsured were in families earning less than 300 percent of the FPL ($51,150 for a family of four in 2000).[ii]

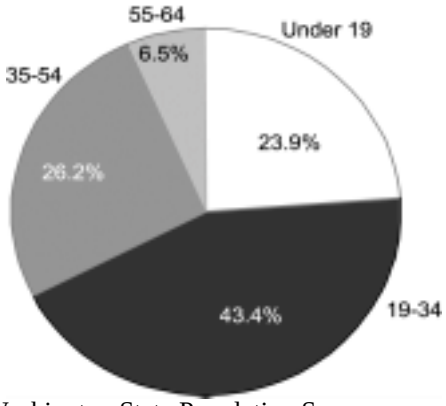
Percent Uninsured by Family Income, 2000



Source: 2000 Washington State Population Survey
Data refer to the under 65 population
Statistical adjustments are for health status, region, number of workers in a family, race/ethnicity, age, education and citizenship

The rate of uninsurance in families with incomes up to 200 percent of FPL is more than twice as high as other income groups, although this discrepancy decreases after controlling for other characteristics that impact the likelihood of being uninsured. However, while the likelihood of being uninsured declines substantially with income, close to 22 percent of the uninsured still have incomes that exceed 300 percent of the FPL.

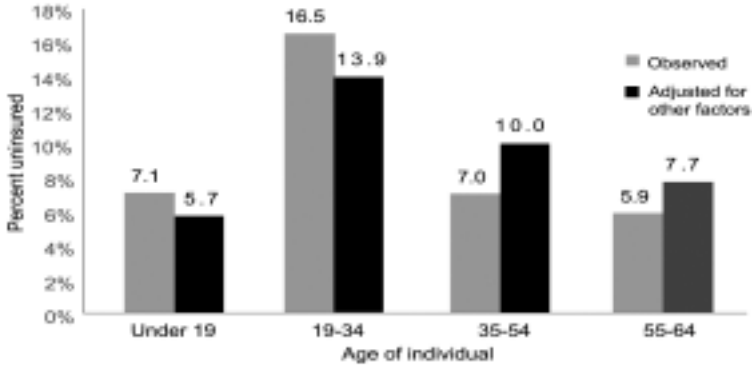
Distribution of the Uninsured by Age, 2000



Source: 2000 Washington State Population Survey.
Data refer to the under 65 population

Young adults aged 19 to 34 make up the largest proportion of the uninsured at 43.4 percent, close to half of those uninsured under age 65. Adults aged 35 to 54 make up the next largest segment, approximately 26.2 percent. The combined group of adults age 19 – 54 who traditionally comprise the bulk of the working force make up close to 70 percent of the uninsured population.

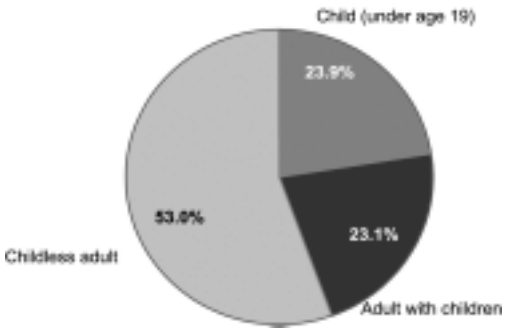
Percent Uninsured by Age, 2000



Source: 2000 Washington State Population Survey. Data refer to the under 65 population
Statistical adjustments are for health status, region, income, number of workers in a family, race/ethnicity, education and citizenship

Rates of uninsurance also vary considerably with age. The rate of uninsurance among young adults is more than twice as high as other age groups. But even after adjusting for other factors, young adults aged 19 to 34 remain the most likely to be uninsured, despite relatively wide access to employment-based insurance (described in Section 2).

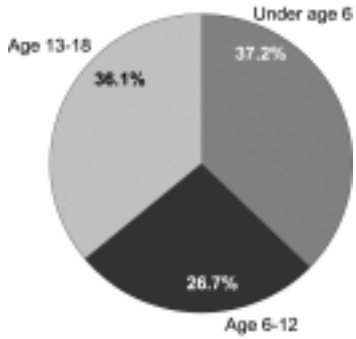
Distribution of the Uninsured by Age / Parental Status, 2000



Source: 2000 Washington State Population Survey.
Data refer to the under 65 population

For young adults aged 19-34, who make up the largest proportion of the uninsured, approximately 60 percent do not have children. This is not surprising since social programs (e.g., Medicaid) have historically targeted children and their parents. The public program available to all adults, Basic Health, currently offers limited access because of enrollment caps driven by public program funding challenges. **More than half of the uninsured, 53 percent, are adults without dependent children**.

Distribution of Uninsured Children by Age, 2000

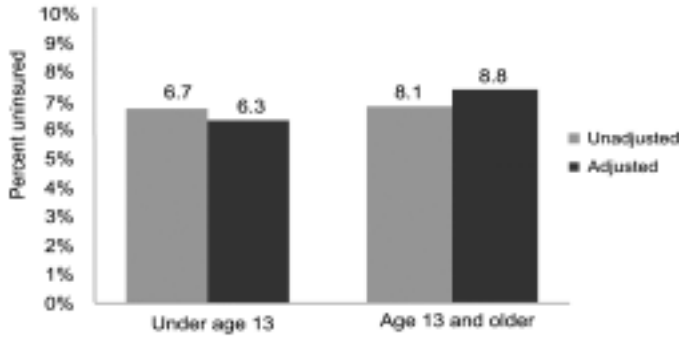


Source: 2000 Washington State Population Survey

The number of uninsured children is fairly evenly distributed among infants, preteen school age children and teenagers. About 60 percent of uninsured children are school age—about 73,000 uninsured children in 2000.

Close to 90 percent of all uninsured children come from families in which all children are uninsured. However, in the 10 percent of families that insure some but not all of the children, **the youngest and less healthy children are most likely to be insured**.

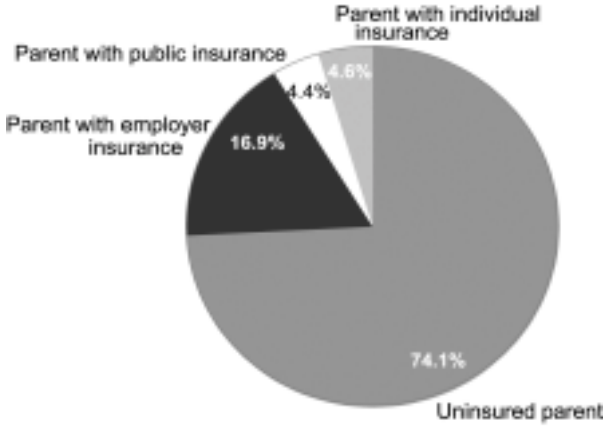
Percent of Uninsured Children by Age, 2000



Among children, the likelihood of being uninsured increases slightly with age. And, after controlling for other factors that influence rates of uninsurance, this discrepancy increases.

Source: 2000 Washington State Population Survey
Statistical adjustments are for health status, race/ethnicity, region, income, number of workers in a family, and education

Distribution of Uninsured Children by Parent's Insurance Status, 2000

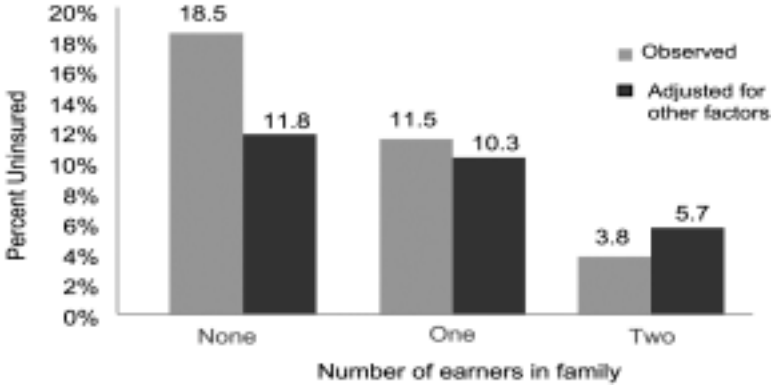


Source: 2000 Washington State Population Survey.

A key factor in predicting the insurance status of children is the insurance status of their parents. Almost 75 percent of uninsured children (almost 86,000 children) have uninsured parents. Children are most often insured when their parents are insured, e.g., only 2 percent of children with an insured parent are uninsured.

Percent Uninsured by Gender: Among children (under age 19) and adults, the likelihood of being uninsured is greater for males than females, however male adults are the most likely to be uninsured. Almost 12 percent of male adults are uninsured, while a little over 8 percent of female adults are uninsured. The discrepancy is less pronounced in children.

Percent Uninsured by Number of Workers in the Family, 2000

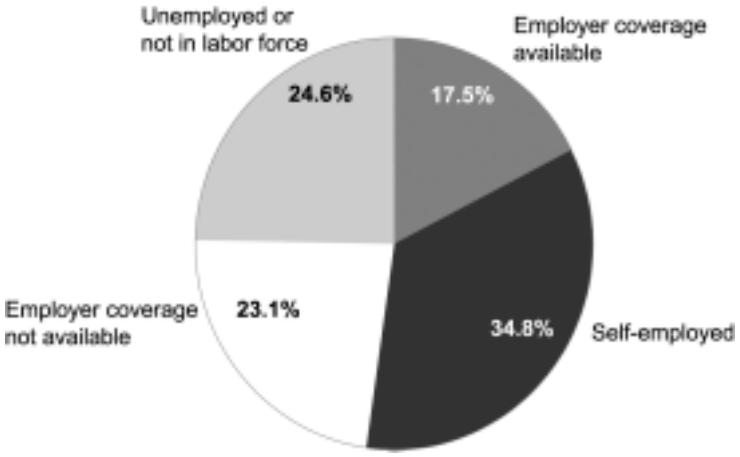


Source: 2000 Washington State Population Survey.
Data refer to the under 65 population
Statistical adjustments are for health status, region, income, race/ethnicity, age, education and citizenship

More than 75 percent (365,000 individuals) of the uninsured are found in families or households with at least one worker. Furthermore, the uninsured rate among those families with no workers, is almost five times the rate in families with two workers and nearly double the rate in families with one worker. This is conceptually consistent with a recent Commonwealth Fund study connecting rising unemployment rates with related loss of health insurance – this study found that the uninsured rate among unemployed adults is nearly three times as high as the uninsured rate in the general population (Lambrew, 2001.[iii])

When adjusted for other factors that influence insurance status the importance of having a worker in the family diminishes as a predictor of uninsurance. However, the likelihood of being insured remains approximately twice as high as in families with two workers.

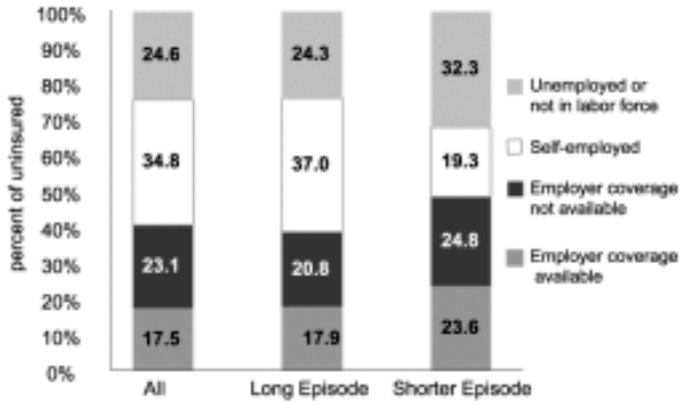
Distribution of the Uninsured by Employment Status and Availability of Employer Coverage, 2000



Source: 2000 Washington State Population Survey.
Data refer to the under 65 population

Although employment remains the cornerstone of insurance in Washington, **being employed does not result in insurance coverage for all working Washingtonians (and their dependents)**. Almost 20 percent of the uninsured have employer-sponsored coverage available and **over 34 percent of the uninsured are in families in which the workers are self-employed**.

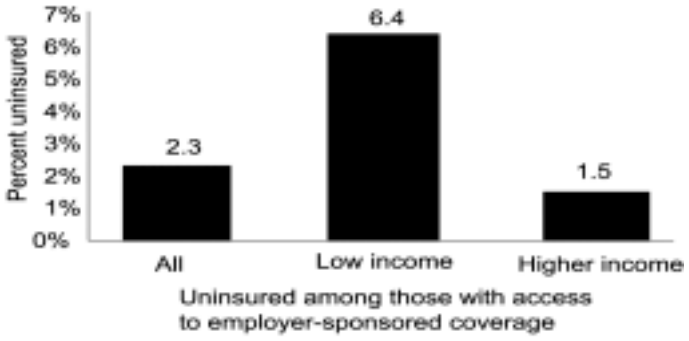
Employment Status and Access to Employer Coverage Among the Uninsured by Duration of Uninsurance, 2000



Source: 2000 Washington State Population Survey and 1997 RWJF Washington Family Health Insurance Survey.
Data refer to the under 65 population
Long episode: 1 year or more
Shorter Episode: Less than 1 year

The duration of uninsurance for workers and their dependents depends on employment status. Self-employed workers comprise a larger share of those uninsured for long periods, in excess of one year. Those without a job comprise a larger share of the transitionally uninsured, i.e., with episodes of uninsurance lasting less than one year. The latter may be explained by the observation that new episodes of uninsurance typically begin with the loss of a job that offered insurance.[iv]

Percent Uninsured by Income Among People with Access to Employer Sponsored Insurance, 2000

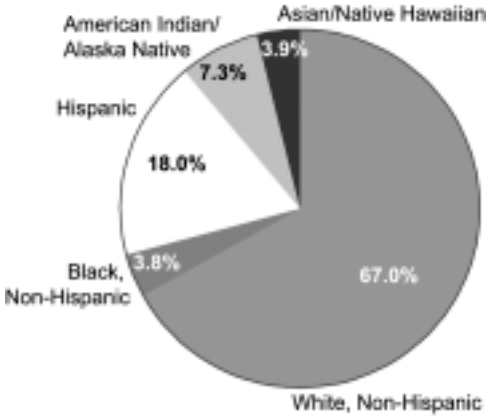


Source: 2000 Washington State Population Survey.
Data refer to the under 65 population

Although they account for 20 percent of the uninsured, only 2 percent of all workers who have access to employer-sponsored coverage are uninsured. Where employees have access to employer-based coverage it is common for them to be insured.

Limited profiling of employer-based coverage, from the employer perspective, is described in Section 2.

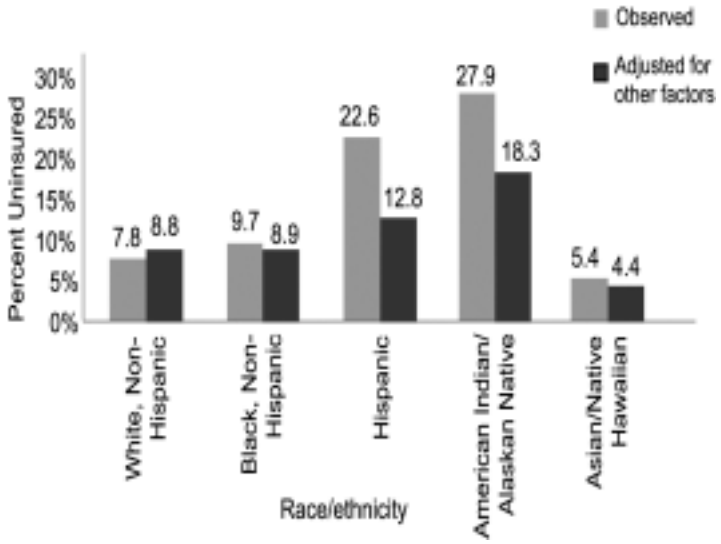
Distribution of the Uninsured by Race/Ethnicity, 2000



Source: 2000 Washington State Population Survey.
Data refer to the under 65 population.

Approximately 67 percent of the uninsured population is White, non-Hispanic. Hispanics account for 18 percent of the uninsured, followed by the American Indian/Alaskan Native group, which comprises a little over 7 percent.

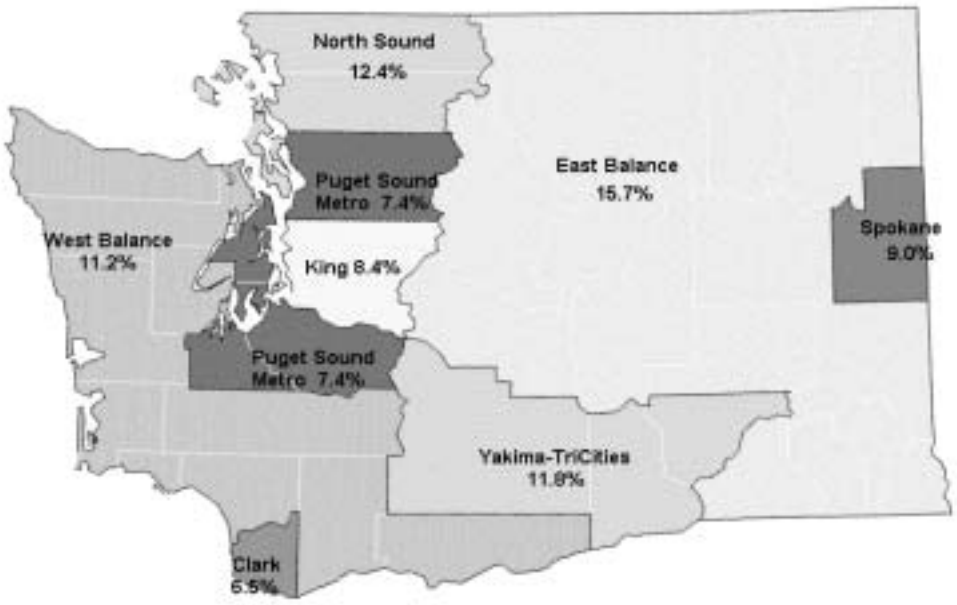
Percent Uninsured by Race/Ethnicity, 2000



Source: 2000 Washington State Population Survey. Data refer to the under 65 population
Statistical adjustments are for health status, region, income, number of workers in a family, age, education and citizenship

Although in sheer numbers the typical uninsured individual is most likely to be White, the likelihood that an individual will be uninsured is highest for American Indians/Native Alaskans at 27.9 percent and for Hispanics at 22.6 percent. Although this disparity declines somewhat when adjusted for other factors that influence uninsured status, these race/ethnic groups remain disproportionately uninsured.

Percent Uninsured by Geographic Region, 2000



Source: 2000 Washington State Population Survey.
Data refer to the under 65 population

WSPS divides Washington state into eight geographic regions. Regions and counties are:

Mostly Urban:

- **Clark**: Clark;
- **Other Puget Metro**: Kitsap, Pierce, Snohomish, Thurston;
- **King**: King;

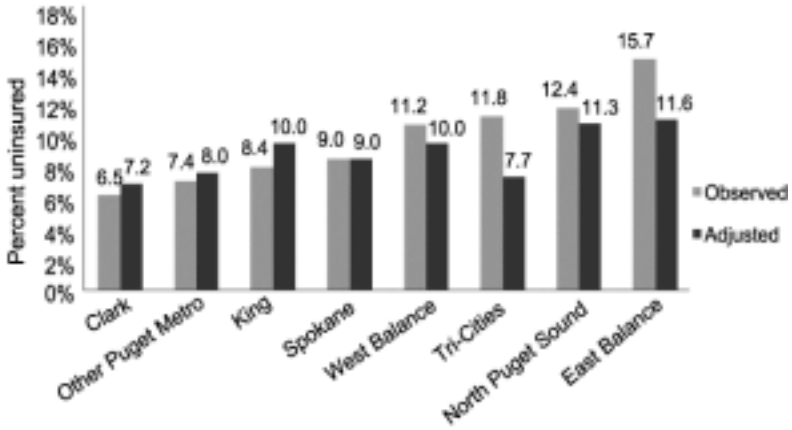
Mixture of Urban and Rural:

- **Spokane**: Spokane;

Mostly Rural:

- **West Balance**: Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Wahkiakum;
- **Yakima-Tri-Cities**: Benton, Walla Walla, Yakima;
- **North Puget Sound**: Island, San Juan, Skagit, Whatcom;
- **East Balance**: Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Stevens, Whitman.

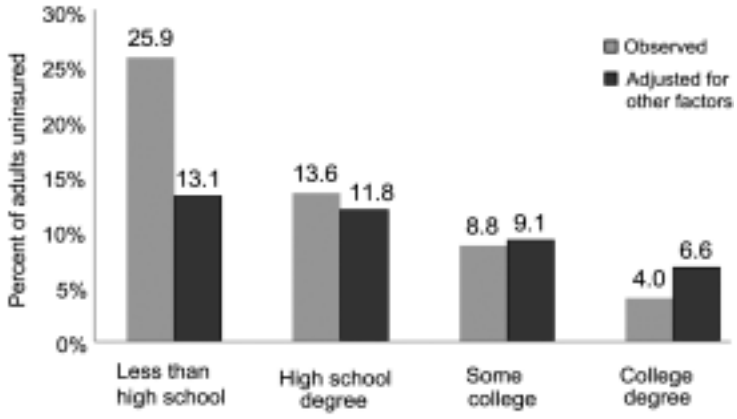
Percent Uninsured by Geographic Region, 2000



Source: 2000 Washington State Population Survey. Data refer to the under 65 population
Statistical adjustments are for health status, race/ethnicity, income, number of workers in a family, age, education and citizenship

The "East Balance" region, which represents most rural eastern Washington counties, has the highest uninsured rate at 15.7 percent. In general, rates of uninsurance are lower in the more urban regions of the state; the lowest uninsured rates occur along the Interstate (I-5) corridor, from Clark County (6.5 percent) to King County (8.4 percent.) Although the uninsured rate is highest in Eastern Washington (excluding the more metropolitan areas of the Spokane and the Yakima-Tri Cities regions), these regional discrepancies are largely due to economic and demographic factors. When we control for these factors discrepancies diminish substantially. Sources of insurance coverage by region are reviewed in Section 3.

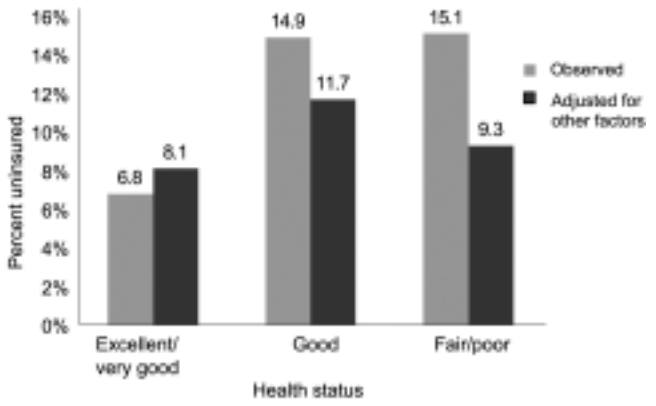
Percent Adults Uninsured by Level of Education, 2000



Source: 2000 Washington State Population Survey. Data refer to adults aged 19-64
Statistical adjustments are for health status, race/ethnicity, income, number of workers in a family, age, region and citizenship

The rate of uninsurance for adults without a high school degree is more than six times as high as the rate with a college degree and nearly three times as high as the rate with some college education. When income and other factors are controlled for, rates of insurance improve less dramatically with increasing education, and the adjusted rate for individuals without a high school degree is only twice as high as the rate with a college degree. These differences are likely related to economic opportunities more available with higher education levels. National studies have shown that the presence of a college degree is positively related to income and is associated with employment in certain sectors and types of jobs that are more likely than others to include a health insurance benefit (Gabel, 1999[v]).

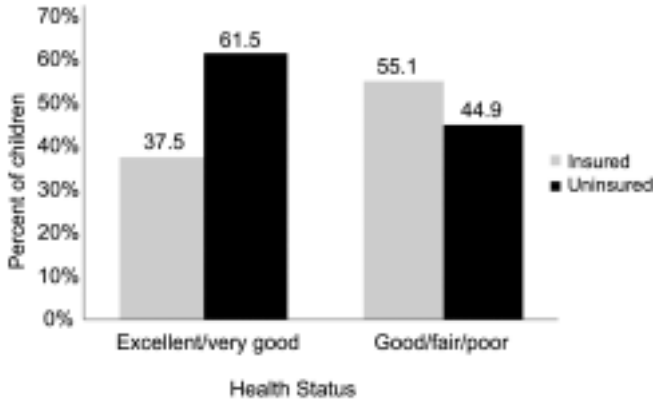
Percent Uninsured by Self-Reported Health Status, 2000



Source: 2000 Washington State Population Survey. Data refer to the under 65 population
Statistical adjustments are for education, race/ethnicity, income, number of workers in a family, age, region and citizenship

Individuals who report that they are in excellent or very good health are less than half as likely to be uninsured as individuals who are less healthy. When we control for other influential factors, individuals in fair or poor health are less likely to be uninsured than individuals in good health, but the likelihood of being insured remains marginally greatest for the healthiest individuals.

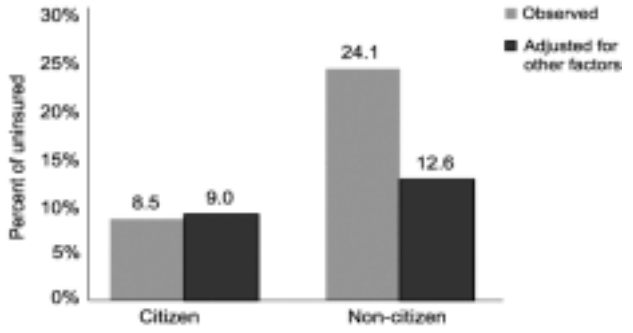
Percent of Children Uninsured in Partially Insured Families by Health Status of Child, 2000



Source: 2000 Washington State Population Survey. Data refer to the under 65 population

This pattern changes in families (with children) that are only partially insured. For these families, children in excellent or very good health (about 62 percent) are more likely to be uninsured than children in poorer health (about 45 percent.)

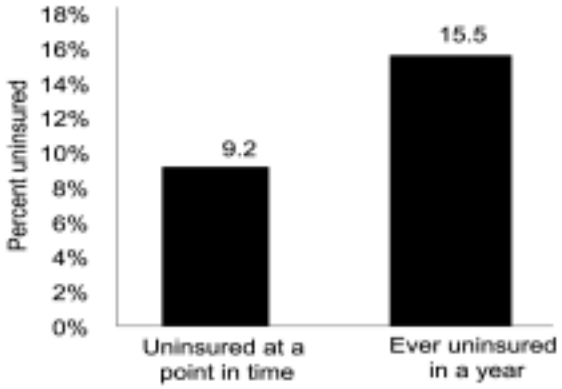
Percent Uninsured by Citizenship Status, 2000



Source: 2000 Washington State Population Survey.
Data refer to the under 65 population.
Statistical adjustments are for health status, region, income, age, education, race/ethnicity, and number of workers in a family

Over 87 percent of the uninsured are United States citizens while 12.6 percent are non-citizens. However, the likelihood of being uninsured is almost three times greater for non-citizens than it is for citizens. This difference dramatically decreases when we control for other factors that influence uninsurance rates.

Percent Uninsured at a Point in Time vs. During the Prior 12 Months, 2000

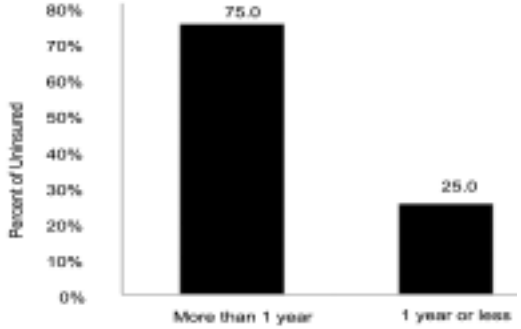


Source: 1998 and 2000 Washington State Population Surveys.
Data refer to the under 65 population

Although for many Washingtonians being uninsured is a transitional state, most of the uninsured are chronically uninsured, i.e., they have been without coverage for at least one year.

Rates of uninsurance are nearly twice as high when measured over the course of a year compared to a single point in time - 9.2 percent of the under 65 population was uninsured in early 2000, but measured over the course of the prior year the rate almost doubles (15.5 percent). Many periods of uninsurance are short-term (i.e., transitional.) However, shortcomings in the availability of transitional state-level data limit analysis of populations making varying transitions; for example, in and out of sources of income, the work force, health status and family relationships.

Percent Uninsured at a Point in Time, by Length of Time Without Insurance, 2000



Source: 2000 Washington State Population Survey and 1997 RWJF Washington Family Health Insurance Survey.
Data refer to the under 65 population

In terms of the duration of uninsurance periods, 75 percent of those who were uninsured at a point in time in 2000 had been uninsured for at least a year.

As with transitional data, current shortcomings in longitudinal data limit in-depth analysis of chronically uninsured individuals.

Relationship to Coverage Strategies:

While we have a high level picture of the uninsured in Washington State, full reflection on current findings is needed in order to build comprehensive profiles where gaps, overlaps and barriers to individual and family coverage are identified. These profiles will be aligned with the analysis of employer-based coverage (see Section 2) and current pathways for coverage (see Section 3) to isolate populations for whom targeted interventions are most pressing. Tight linkages between these populations and proposed interventions (see Section 4) will become the foundation for broad-based input on opportunities for improving coverage and access.

SECTION 2. EMPLOYER-BASED COVERAGE

Analytic Focus:

Options for expanding employer-based coverage continue to be of particular interest to a broad set of Washington's stakeholders. Significant work occurred in Washington in the mid 1990s to understand the characteristics and motivations of employers who offer and do not offer coverage. A goal of Washington's grant analysis was to build upon these previous descriptive efforts and in particular to understand more about small employers. Analysis focused on:

a. Identifying the best sources of available employer data to establish a baseline for further analysis and to develop strategies for filling the gaps in data

b. Profiling employers and their workers to understand the characteristics and circumstances surrounding the likelihood that a worker is employed in a business offering health coverage

c. Employer values, decision-drivers and areas of ambivalence in offering coverage to employees

d. The scope of products available in the small group market.

Methods:

a. Sources of data have been compiled, summarized and analyzed to define the employer-based data that are available. Details on the state's data collection strategy are captured in Section 8. Profiling analyses were based primarily on data collected in the 2000 Washington State Population Survey (2000 WSPS), however, constructs important for employer analyses were not all available in the 2000 WSPS. As described in Section 8, our consultant team devised approaches to fill key data gaps through:

   (i) synthetically matching each worker in the 2000 WSPS to an employer in the 1997 RWJF Employer Health Insurance Survey, and thereby attaching all the characteristics of a single employer to each worker, and

   (ii) imputing premiums that would have to be paid for workers in businesses that do not offer coverage based on understanding characteristics of businesses that do offer coverage.

b. Analyses of employer-based coverage looked at the distribution of workers across types of employers, examined the characteristics of employers associated with the likelihood of that insurance is offered as a benefit, and the effect of workforce composition on demand for insurance. As with the profiling of individuals simple bivariate and multivariate analyses and adjusted relationships highlighted the underlying causes of uninsurance. Implications for Washington's small employers in relation to decisions to continuing to offer insurance, let alone opportunities for offering new insurance benefits are still to be determined.

c. Findings from the multi-purpose Private Insurance Carrier Survey, and analysis of national and proprietary employer-based survey data sources, assisted us in understanding the range of products available in the small group market. However, this aspect of our work did not fully pan out as anticipated; findings have been somewhat limited by the narrow scope of responses and lack of precision in readily available data.

d. Our original intent was to use focus groups as an opportunity for guided discussion to understand employer and employee values, however our approach has evolved for two reasons.

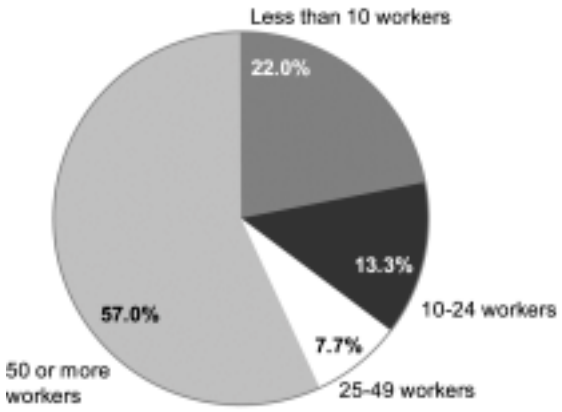
(i) Initial framing of the focus group protocol occurred absent details of employer profiles and alignment of targeted populations with potential options. In reviewing preliminary progress we determined with our consultant team that information needed to guide the work was incomplete. Thus we put further efforts on hold until our analysis of profiles and potential options strategies yielded a compelling framework for grounding our exploration of employer values and decision-drivers.

(ii) From analysis of employer profiles we had anticipated that the need for a focused survey of employers would emerge later in our process. Given the elevated interest from private and public leaders in stimulating opportunities to engage employers, individuals and communities in collectively building solutions, this may still be necessary. However, we found that a community-based project in eastern Washington is now pilot-testing a survey to assess small employer needs and interests vis-à-vis an alternative employer-based approach to offering coverage. We now anticipate that building on this work, rather than re-inventing the wheel, would be a much more efficient path to take to understand employer values and decision-drivers.

Findings:

Findings below reflect highlights from the consultant team's analyses to-date; the order of presentation parallels that requested by HRSA.

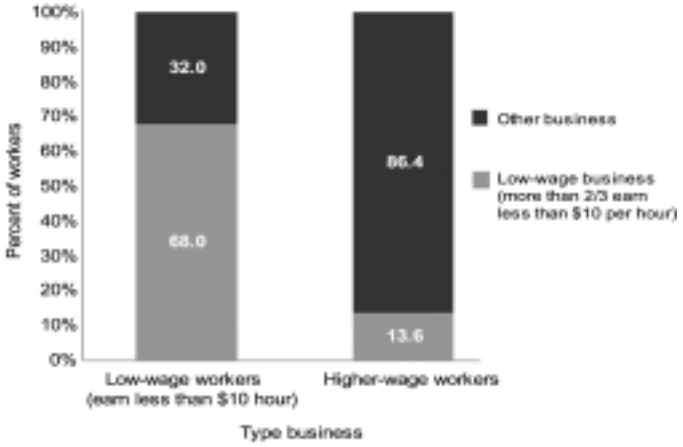
Distribution of Workers by Size of Business, 2000



Source: 2000 Washington State Population Survey, 1997 RWJF Employer Health Insurance Survey
Data refer to the under age 65 population of workers only (i.e., dependents not included)

Almost 60 percent of workers are employed in businesses with 50 or more employees, 22 percent are employed in very small businesses with fewer than 10 workers, and 21 percent are employed in mid-size businesses ranging from 10-49 workers.

Distribution of Low and Higher Wage Workers by Wage Characteristics of Business, 2000

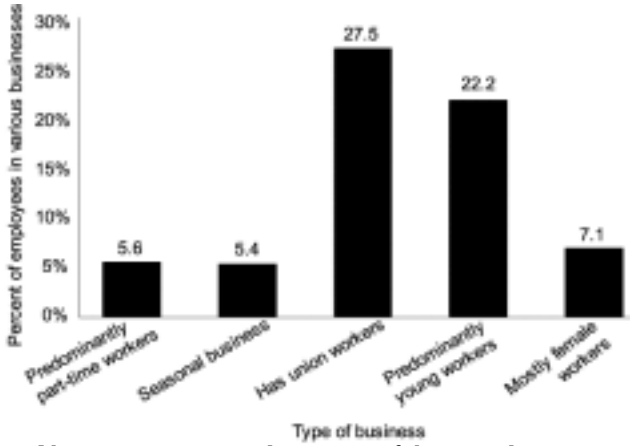


About 20 percent of workers are employed in businesses in which at least two-thirds of the workers earn less than $10 per hour. (Effective January 1, 2002 Washington's minimum wage is $6.90.) These businesses are defined as low wage businesses and they employ most of the low wage workers. However, almost one-third of their workers are not defined as low wage.

A table displaying the proportional distribution of workers by characteristics of their employers is included in Appendix III, Section 2.

Source: 2000 Washington State Population Survey, 1997 RWJF Employer Health Insurance Survey
Data refer to the under age 65 population of workers only (i.e., dependents not included)

Distribution of Workers by Type of Business, 2000

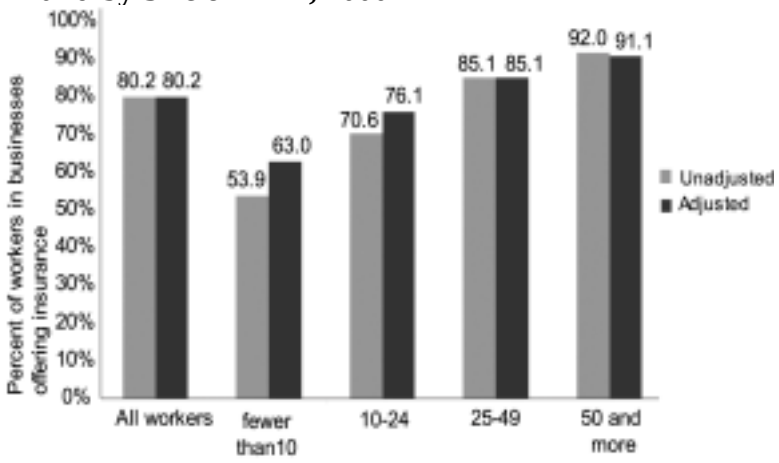


Seasonal businesses report at least 50% of their employees as seasonal or temporary.
Part-time businesses report over 50% of their employees work fewer than 20 hours per week.
Predominantly young businesses report at least 30% of their employees are under age 30 and no employees are over age 50.
Mostly female businesses report 90% or more of their employees are women
Union businesses report that varying proportions of employees are unionized.

Source: 2000 Washington State Population Survey,
1997 RWJF Employer Health Insurance Survey
Data refer to the under age 65 population of workers only (i.e., dependents not included)

Businesses with a primarily seasonal, part-time or mostly female work force each employ fewer than 10 percent of all employees, i.e., they represent small numbers of the uninsured. However, these employees are least likely to have insurance provided by their employer, even after adjusting for employer size, wages and other characteristics that impact the likelihood of an employer offering coverage. They are clearly disproportionately uninsured. Workers employed in businesses that are unionized (about 28 percent of the work force) are almost always offered insurance (over 99 percent of the time.)

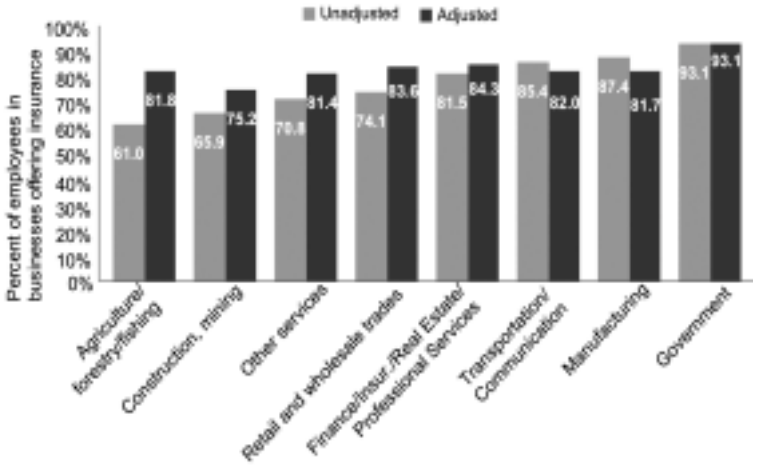
Percent of Workers in Firms Offering Health Insurance, All and by Size of Firm, 2000



Source: 2000 Washington State Population Survey, 1997 RWJF Employer Health Insurance Survey.
Data refer to the under age 65 population of workers only (i.e., dependents not included)
Statistical adjustments are for characteristics likely to affect insurance offers including seasonality, unionization, and presence of young, female, low-wage, or part-time workers.

In total, about 80 percent of all workers are employed in businesses that offer coverage. However, workers in large businesses are much more likely to be offered coverage than workers in small businesses. **Only about 54 percent of workers in businesses with fewer than 10 workers are offered coverage (representing approximately 12 percent of all workers),** while 92 percent of workers in businesses with 50 or more employees are offered coverage (representing approximately 52 percent of all workers.) Little change in this discrepancy occurs even after adjusting for other factors that impact the likelihood of an employer offering coverage.

Employees in Businesses Offering Insurance by Industry of Employment, 2000



Industries differ in their likelihood of offering insurance. Employees in local, state, or federal government positions are most likely to have an employer that offers insurance while those in the agriculture, forestry, or fishing industries are the least likely. However, these differences are largely due to other characteristics that are associated with both industry and offering insurance (e.g., size of business or seasonality of workers). As a result, the differences diminish substantially after adjusting for these characteristics.

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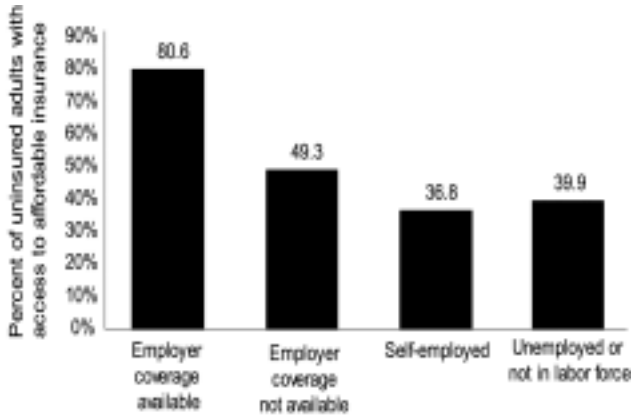
Source: 2000 Washington State Population Survey, 1997 RWJF Employer Health Insurance Survey.
Data refer to the under age 65 population of workers only (i.e., dependents not included)
Statistical adjustments are for characteristics likely to affect insurance offers including seasonality, unionization, and presence of young, female, low-wage, or part-time workers.

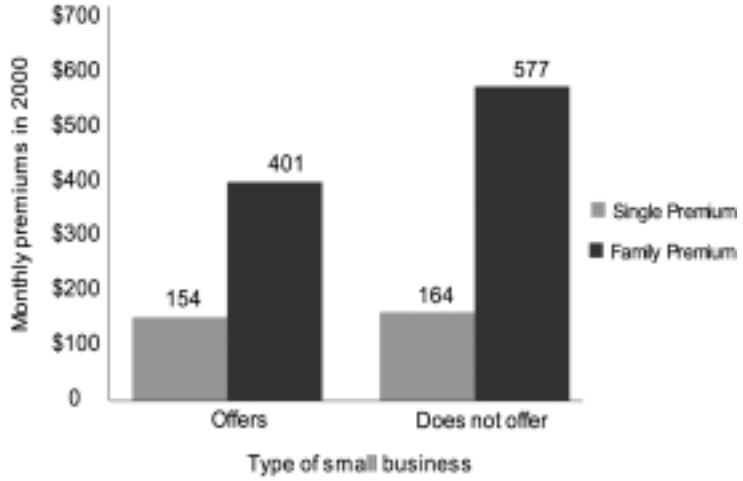
Access to Affordable Insurance Among Uninsured Adults by Type of Private Coverage Available, 2000



Source: 2000 Washington State Population Surveys.
Data refer to adults age 19-64

Our analysis suggests that over 80 percent of uninsured adults for whom employer coverage is currently available are likely to be able to afford that coverage. However, less than 50 percent of adults who do not have access to employer coverage or who are self-employed or unemployed, have access to affordable coverage. Even though self-employed adults are eligible for subsidies through the tax system, they are the least likely to have access to affordable insurance. They currently have very limited access to public programs and other options are more expensive.

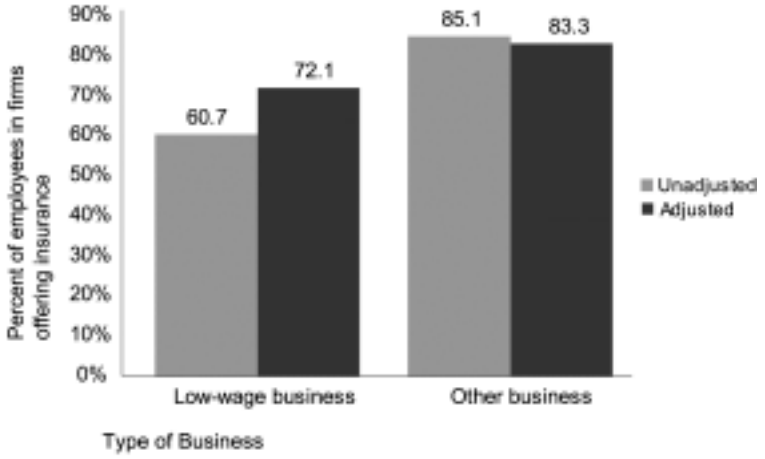
Monthly Premiums Paid by Small Firms Who Offer Insurance and Predicted for Those Who Do Not Offer, 2000



Source: 2000 Washington State Population Survey, 1997 RWJF Employer Health Insurance Survey.
Small firms are those with 50 or fewer employees.

Lack of availability of employer-sponsored insurance is primarily a problem for workers in small businesses since most large businesses do offer coverage. Price appears to be a limiting factor. Total (predicted) premiums that would have to be paid for insurance by small businesses (50 or fewer workers) that do not offer coverage are higher than the actual premiums paid by businesses that do offer insurance. (See Appendix III, Section 8, Methodology for Developing Key Data Constructs Not in WSPS.)

Employees in Businesses Offering Insurance by Predominant Wage Level of Business, 2000



Source: 2000 Washington State Population Survey, 1997 RWJF Employer Health Insurance Survey.
Statistical adjustments are for characteristics likely to affect insurance offers including size of firm, seasonality, unionization, and presence of young, female, or part-time workers.
Low Wage businesses are those in which more than 2/3 of workers make less than $10 per hour

Since characteristics of the employer's workers (such as low wage, predominantly young, mostly female) are related to the likelihood that insurance is not offered, even after adjusting for other influences, worker demand may be a factor in employer decisions to offer insurance. For example, workers in businesses with a large share of low-wage workers are less likely than workers in other businesses to be offered coverage. Caution is suggested by this analysis - strategies that include subsidies for employers but do not consider the economic characteristics of workers (e.g. their low income) likely will have little impact on uninsurance.

Relationship to Coverage Strategies:

As noted, interest is keen on strategies that support and build on the employer-based system of coverage in Washington. These strategies must be grounded in information about the uninsured, individual and market affordability, and the underlying pressures, trade-offs and other factors balanced by employers in their decisions to provide coverage to their employees. The expectation is that engaging impacted parties in guided discussion based on solid information will yield the most effective opportunities for refining employer participation in the health care system.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

Methods: Washington's analysis of the marketplace is captured through three approaches: marketplace pathways to coverage, private and public; assessment of income adequacy and affordability of insurance products; and marketplace feedback. Secondary data from a variety of existing data sources (e.g., research, industry, regulatory, and administrative databases) was used. In addition, primary data collection was initiated through a marketplace survey and a follow-up focus group with select insurance carriers and third party administrators. Specific areas of focus and methods for each area are explained below:

a. **Pathways to Coverage and Care:**

This analysis focused on capturing and understanding the various pathways (options) that people currently have for coverage and access, and where the gaps and overlaps exist. The 2000 Washington State Population Survey (WSPS) provided the basis for identifying the pathways, including employer coverage, publicly subsidized coverage, the individual market, and high risk pool. Public program eligibility requirements are linked with WSPS population characteristics to assess the primary eligibility pathways for different segments of the population and factors that are likely to affect availability of insurance such as income, age, citizenship status, and medical condition. The availability of employment-based coverage is also assessed, using a synthetic data set constructed from WSPS and the 1997 RWJF Employer Health Insurance Survey (see Section 2 and Appendix III, Section 2 for more detail).

b. **Affordability – A Measure of Income Adequacy and an Affordability Index:**

- **Income Adequacy:** To understand more about affordability as a specific barrier to coverage, we evaluated four available measures of income adequacy. We selected the measure that best allowed us to consider both family income and expenses and account for differences in these components across family types and geographic regions in Washington - *The Self-Sufficiency Standard for Washington State* developed by Diana Pearce (2001). Using grant-specific survey results on premium costs for coverage available in Washington and actuarial estimates of out-of-pocket health care expenses, we estimated total out-of-pocket costs. These costs were applied to the *Self-Sufficiency Standard for Washington* to create an *Adjusted Self-Sufficiency Standard,* which is the basis for our assessment of income adequacy around the State. Detailed descriptions of *The Self-Sufficiency Standard for Washington State* and the methodology for enhancing it to derive the *Adjusted Self-Sufficiency Standard* are included in Appendix III Section 3.
- **Affordability Index:** *The Self-Sufficiency Standard for Washington State* was also used as the basis for estimating accessibility of affordable coverage. Our consultant team linked the *Self-Sufficiency Standard for Washington* to individuals in the 2000 Washington State Population Survey and incorporated more precise health care expenses (based on actual family composition, geography, employment status and income). From this base an affordability index was developed for each individual and family in the survey to estimate the numbers and characteristics of families who have access to affordable coverage.

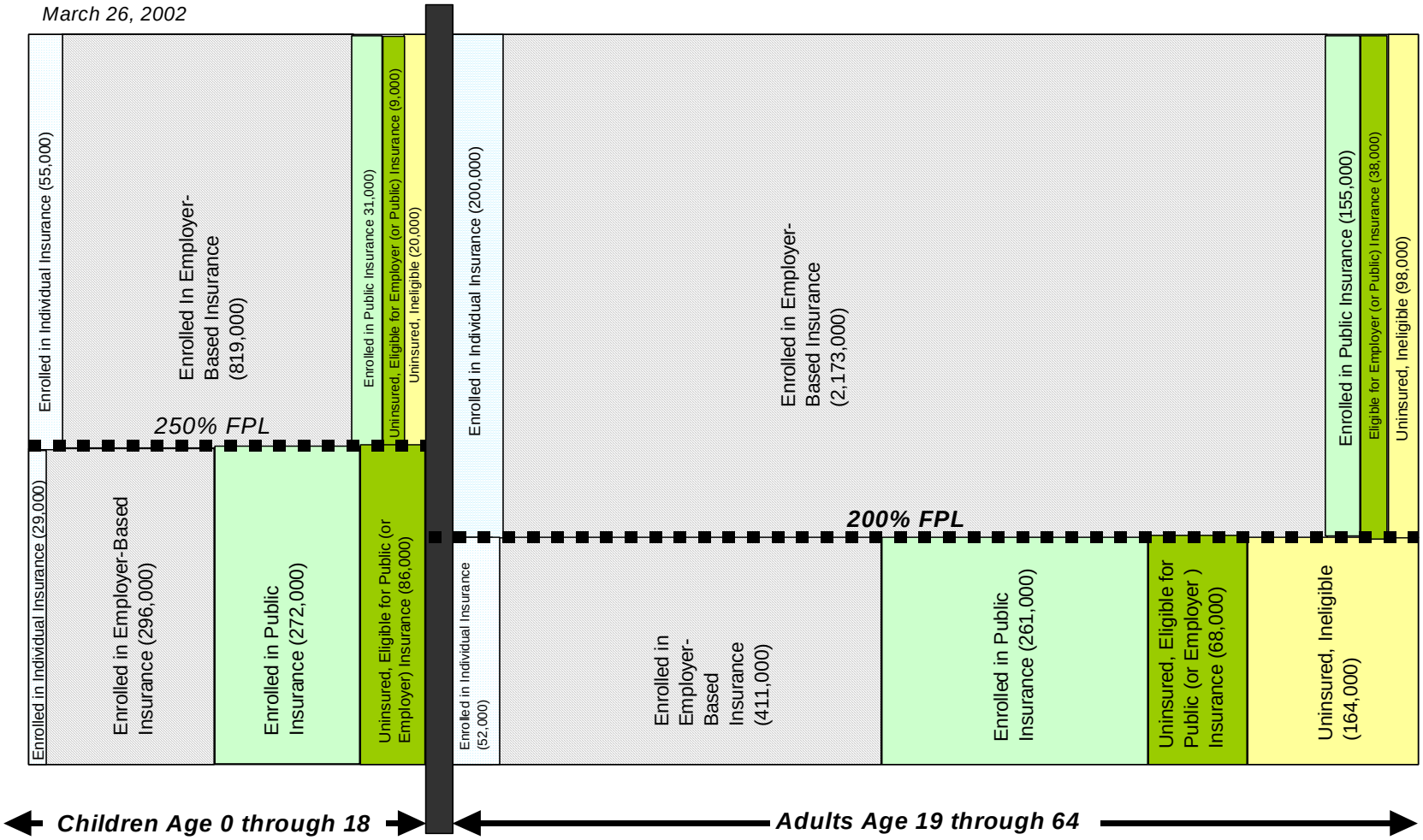
c. **Marketplace Feedback:**
To augment the existing data sets, the consultant team conducted primary data collection through a marketplace survey of targeted carriers and third party administrators with a follow-up focus group. The resulting data provide feedback on the health care system and potential changes in the marketplace.

Findings:

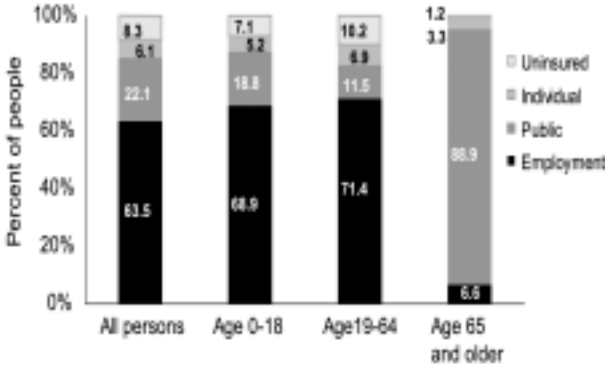
a. Pathways to Coverage and Care:

The major pathways to coverage, or sources of insurance coverage, in Washington were examined with analysis of how the types of insurance coverage vary according to factors such as income, geography, and ethnicity or race. A draft graphic of the pathways to coverage in Washington is attached below as one display of enrollment and access options. More detailed breakdowns of the insurance coverage are described in the following pages.

***DRAFT – Work in Progress* : Pathways to Coverage**
Enrollment and Access to Insurance Coverage in Washington, Under Age 65, 2000



Primary Source of Insurance Coverage by Age Group, 2000



Source: 2000 Washington State Population Survey.

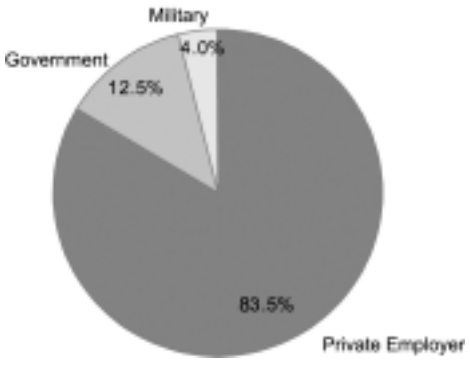
Sources of insurance vary with age. Public insurance is dominant for those over age 65, with 88.9% primarily covered by Medicare, and only 6.6% receiving primary coverage through an employer. Employer-based insurance is predominant for other age groups, although almost one in five children in Washington is primarily covered by public plans.

Employment-based insurance remains the largest single source of insurance coverage, covering nearly 71% of the population under age 65. The individual insurance market provided coverage for about 6% of the population in 2000, while public insurance programs (defined as Medical Assistance programs, SCHIP and Basic Health) covered nearly 14% of the population.

Primary Source of Insurance Coverage for those Under Age 65, 2000

Source

Major Sources of Employer Coverage for Workers and Their Dependents Under Age 65, 2000

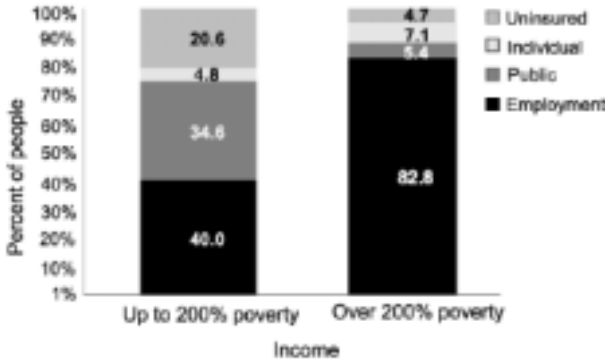


Source: 2000 Washington State Population Survey

Of those with coverage through the employment-based sector, nearly 84% had insurance provided by a private employer, nearly 13% by federal, state and local governments, and 4% by the military.

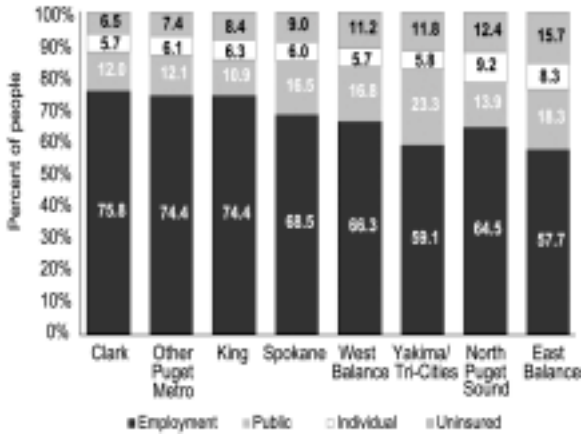
The source of insurance coverage varies substantially by income. The likelihood of having employer coverage is twice as high among those with incomes above 200% of poverty compared to those with lower incomes. Public insurance fills the gaps for many low-income individuals, more than one-third of whom are insured through public programs. (A broader description of the array of public programs follows below.)

Sources of Insurance (and Uninsured) Above and Below 200 Percent of the Federal Poverty Level, 2000



Source: 2000 Washington State Population Survey. Data refer to the under age 65 population.

Sources of Insurance (and Uninsured) by Region, 2000



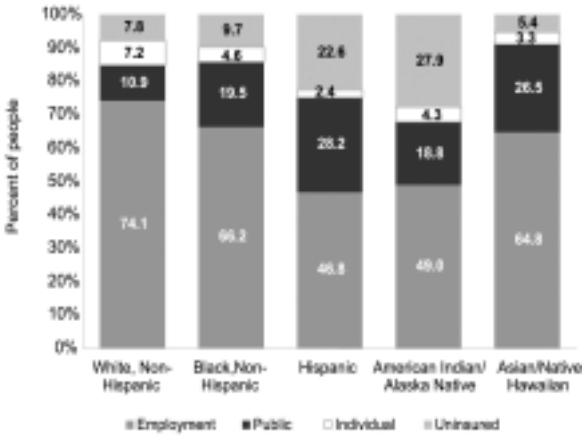
Source: 2000 Washington State Population Survey. Data refer to the under age 65 population.

Source of coverage also varies by region. Three out of four of the under 65 population has an employment-based plan in highly urbanized Clark and King Counties, and in other parts of the Puget metro area. In the more rural counties, employment-based plans cover about two-thirds of the population or less. For public coverage a reverse pattern exists, with one in ten King County residents covered by a public plan, in contrast to almost one in four with public coverage in the Yakima/Tri-Cities area. (This parallels a concerted focus of the community clinic in the Yakima/Tri-Cities area on outreach and enrollment into public coverage.)

Regions and counties are: Clark**: Clark;** Other Puget Sound Metro**: Kitsap, Pierce, Snohomish, Thurston;** King**: King;** Spokane**: Spokane;** West Balance**: Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Wahkiakum;** Yakima-Tri-Cities**: Benton, Walla Walla, Yakima;** North Puget Sound**: Island, San Juan, Skagit, Whatcom;** East Balance**: Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Stevens, Whitman.**

The source of insurance coverage also varies by race and ethnicity. While three out of four non-Hispanic Whites have employment-based insurance, only about half of Hispanic and American Indians/Alaskan Natives have employment-based insurance. More than a quarter of Hispanics and Asians/Native Hawaiians have public insurance. American Indians/Alaska Natives have the highest uninsured rate at 27.9% and over one in five Hispanics are uninsured.

Insurance Coverage by Race or Ethnicity, 2000



Source: 2000 Washington State Population Survey Data refer to the under age 65 population.

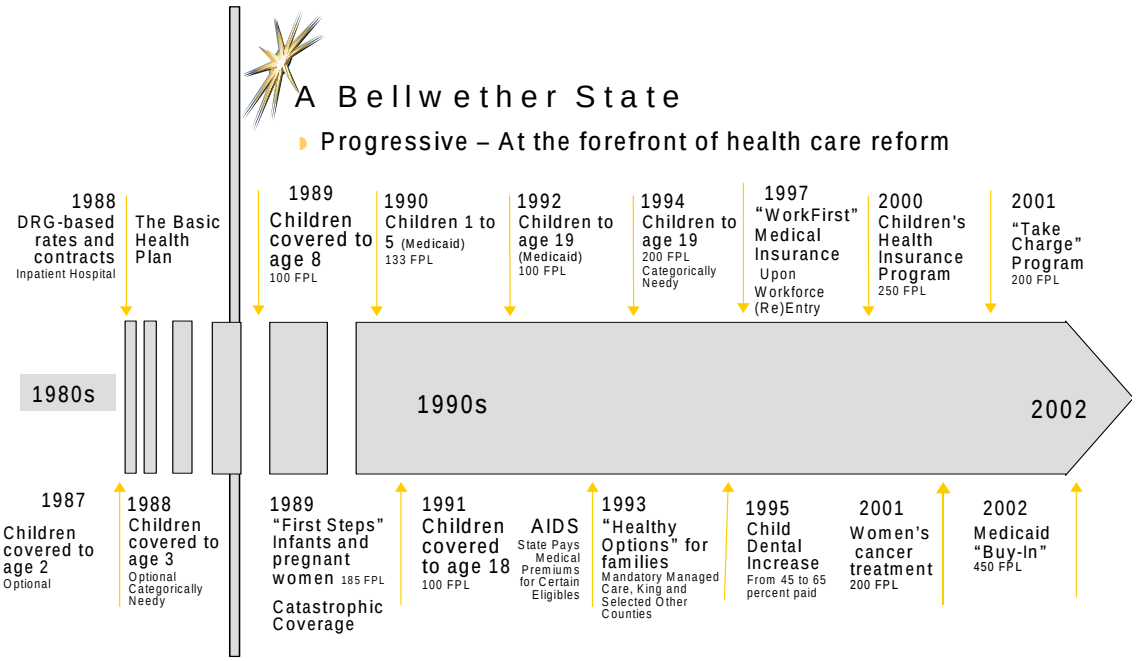
An additional program known as the Washington State Health Insurance Pool (WSHIP) is available for high-risk individuals that have been denied access to coverage from the individual market. Legislation passed in 2000 re-instituted the individual market in 2001 (prior to this the individual market was closed to all new enrollees). An element of the Legislation allows insurance carriers to screen out 8 percent of the sickest applicants, who then are eligible for the high-risk pool. Enrollment in the risk pool is very small, approximately 2,200 per month, representing less than one-half percent of the insured population. Preliminary findings from the assessment of income adequacy indicate families may need a minimum income equivalent to 250% of the federal poverty level (FPL) before they could reasonably afford these premiums.

The main pathway to coverage for the majority of Washington residents is through employer-sponsored coverage. A more in-depth review of employer insurance characteristics is discussed in Section 2. Another key pathway to coverage, especially for the lower income population, is publicly subsidized coverage. Washington's public insurance pathway is explored in more detail below.

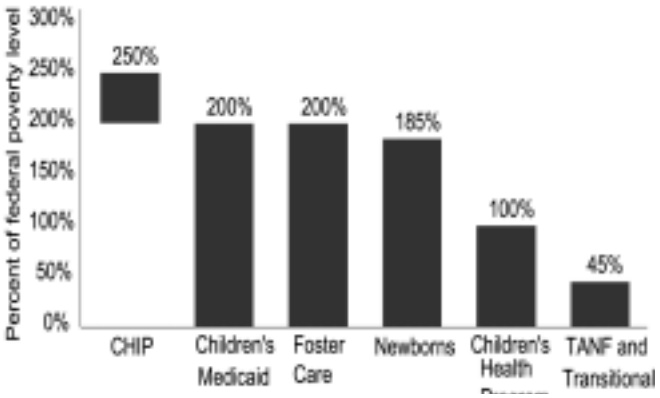
Availability of Insurance:

Availability of private, employer-based coverage for workers and their dependents is discussed in Section 2. The following discussion focuses on the availability of public insurance.

As noted above, 13.7% of all persons in the state (under age 65) were insured through public coverage in 2000. Washington has a variety of publicly subsidized insurance programs built over time to provide access to coverage for low-income and vulnerable populations, including a relatively unique subsidized sliding scale program called Basic Health. In addition to Basic Health, a series of public program expansions has been built over upon the Medicaid programs, including SCHIP. The chart below (courtesy of Washington State Medical Assistance Administration, Department of Social and Health Services) summarizes the history of expansion efforts in Washington over the past fifteen years – with particular emphasis on Medicaid-related expansions. The innovations began in earnest in the late 1980s, with a series of medical coverage expansions for children (ultimately resulting in a comprehensive eligibility framework for all children, ages 0 through 18), pregnant women and infants, and low-income working individuals and families.



Washington Public Insurance Programs for Children by Income Eligibility

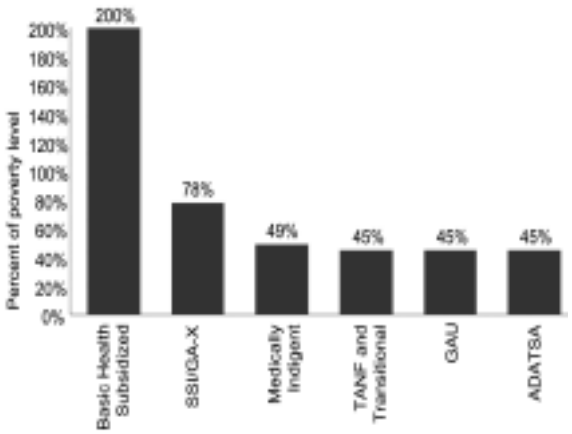


Source: Medical Assistance Administration

Public coverage programs are widely available for children. Most children with family incomes below 250% FPL have access to coverage through SCHIP, Children's Medicaid (including Basic Health), and other targeted Medical Assistance programs. One state-funded Medical Assistance program for non-citizen children will be eliminated and children (and non-citizen adults) will be "transitioned" to Basic Health by 2003.

Focusing on programs widely available for adults reveals more limited access to publicly subsidized coverage than children experience. Medicaid programs are available for parents with dependent children with net family incomes below 45% FPL (through the Temporary Assistance for Needy Families-TANF eligibility). In general, the other Medical Assistance programs are only available to persons with specific disabilities (e.g., SSI disability) and low-incomes (e.g., 78% FPL); or for specific medical conditions (i.e., pregnancy; breast and cervical cancer; drug or alcohol treatment). The other option available more broadly to low-income adults at or below 200% FPL (gross income) is the Basic Health program, however the program has funding and enrollment limitations, with waiting lists for enrollment.

Selected Washington Public Insurance Programs for Working-Age Adults by Income Eligibility



Source: Medical Assistance Administration and Basic Health.

The largest programs in terms of enrollment include TANF Family Medical with approximately 271,000 enrollees, and Children's Medicaid (mandatory and optional populations) with approximately 309,000 enrollees (*per administrative data for January 2002*). SCHIP represents a relatively small portion of children (approximately 6,500), and Basic Health includes approximately 131,000 adults. Most children enrolled through Basic Health are in Basic Health Plus, a fully coordinated Medicaid program included in Children's Medicaid. Significant numbers are also served in programs targeted toward disabled populations and the elderly (i.e., SSI general assistance; long term care programs; and Medicare cost-sharing). The entire array of Medical Assistance Programs (including SCHIP) serves over 895,000 people.

b. Affordability – A Measure of Income Adequacy and an Affordability Index:

Results from the affordability analysis provide insights into the comparison between what individuals can afford to pay for coverage and care compared to the reality of what's available to them (our measure of income adequacy). Findings also provide a sense of the numbers of uninsured families with access to affordable coverage and the characteristics of the uninsured who do and do not have such access (our affordability index.)

Although results are preliminary and we have not yet had time to fully internalize their significance, they represent considerable strides for Washington in building a relevant measure of affordability. Work also demonstrates the complexity of developing a measure that is valid, accurate and easy to apply. The challenge now is to find ways to translate findings for use by policy makers. Equally important, we anticipate that the results will have broad utility for existing public programs, beyond the work of the grant. For example, the Department of Social and Health Services is currently negotiating refinements in its federal Medicaid waiver, which will likely include some cost-sharing for selected enrollees. The Health Care Authority is evaluating refinements needed to its programs (i.e., the program for public employees and the Basic Health program for low-income residents) for upcoming procurement negotiations. Washington expects the affordability analysis to provide on-the-street grounding in the discussion of design elements such as premium sharing and point-of-service cost sharing levels for these programs.

1. <u>The Income Adequacy Measure</u>

Comparison of Measures of Income Adequacy:

We reviewed a variety of available measures of families' economic status and selected four for in-depth comparative analysis:

- the federal poverty level (FPL),
- 50 percent of median family income (measured at the county level),
- the full-time minimum wage, and
- the *Self-Sufficiency Standard for Washington State* developed by Diana Pearce (Pearce, 2001). (A detailed description is included in Appendix III, Section 3.)

The analysis that culminated in the selection of *The Self-Sufficiency Standard for Washington State* as the foundation measure of income adequacy for our work is also included in Appendix

III, Section 3. We wanted a measure that considered both income and expenses and one that accounted for differences in these components across family types and geographic regions. The Standard is the single measure among the four evaluated for which this is true. However, the Standard assumes that health insurance is universally available through employment and includes a health cost factor based on this assumption – this does not provide a level of exactness needed for our analysis and we therefore incorporated revisions (working with Diana Pearce) to increase the precision of the Standard, creating an *Adjusted Standard*.

The Adjusted Standard: Our consultant team's methodology for developing the *Adjusted Standard* as the basis for our assessment of incomes adequate to meet basic living expenses is included in Appendix III, Section 3. Basic living expenses are recalculated for 12 family types in counties representing each of the eight WSPS regions of Washington, including a refined health cost estimate. Health costs included are based on actuarial estimates of out-of-pocket costs for three levels of health status (healthy, average and sick) and premium costs for the coverage options most likely available to low-income Washingtonians (Medicaid, Basic Health, example Individual and Small group products, and the Washington State Health Insurance Pool.)

The *Adjusted Standard* allows us to answer the question: **"At what income level can family type *a*, living in county *b*, with health status *x* afford to buy coverage option *t* after paying for other basic living expenses?"**

> For example, in 2001, a healthy, single adult (age 20) living in Whatcom County would need a total annual income of $15,358 to be able to afford to enroll in Basic Health and also have enough money to pay remaining living expenses without other public subsidies. The federal poverty level equivalent is approximately 179 percent. The same individual needing to purchase private coverage would require an annual income of $16,809 (equivalent to approximately 196 percent FPL) to purchase on the individual market or $17,442 (equivalent to approximately 203 percent FPL) to purchase through WSHIP.

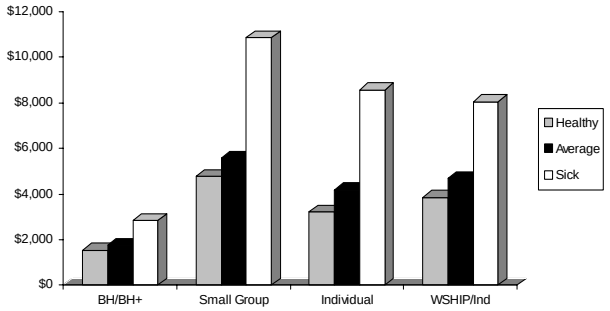
When arrayed along the multiple analytic dimensions (family types, regions, health status levels and coverage options) we obtained over 1,800 income adequacy measurements. Initial findings show that:

- The Adjusted Standard is greater than 100 percent FPL for all family types in all counties for all coverage options for which the family with enough income to pay living expenses (including health expenses) is eligible. That is, families need incomes greater than 100 percent FPL to cover their basic living expenses, even with Medicaid coverage. When families have to pay for health care and receive no other subsidies, the Adjusted Standard ranges from a low of 120 percent FPL for a healthy family living in King County with two adults and two teenagers, to a high of 362 percent FPL for a sick family in King County with one adult and four children, to purchase individual insurance. Between these two extremes, there is much variation by family type, county, health status, and coverage option.
- In general, public program subsidies associated with the Basic Health program appear to bring health care costs to a level that is affordable for most family types. However, in reality, families that can meet their basic living expenses with enough money left over to pay for out-of-pocket health care costs frequently have incomes higher than 200 percent of the FPL.
- Premiums vary substantially in this analysis. For example, premiums for Medicaid coverage are assumed to be zero and are therefore the lowest for all families. Premiums for the state-subsidized Basic Health program are lower than private options for all families. Premiums for individual coverage are lower than for small-group coverage for all one adult families except the largest families with one adult and 5 children.
- Total out-of-pocket health care expenses vary dramatically by family size, health status, and coverage option. The figures below illustrate this point for two family types.

For families with one adult and one school age child purchasing individual insurance, sick families pay 267 percent of the health care expenses paid by healthy families. For families with two adults, one infant and one preschool child purchasing individual insurance, sick families pay 183 percent of the health care expenses paid by healthy families.

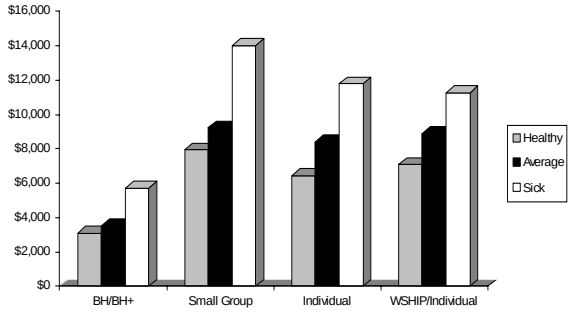
For families with one adult and one school age child enrolled in small-group coverage, sick families pay 381 percent of the health care expenses paid by the same family enrolled in Basic Health. For families with two adults, one infant and one preschool child, sick families pay 245 percent of the health care expenses paid by the same family enrolled in Basic Health.

Annual Health Care Expenses by Health Status: 1 Adult, 1 School-Aged Child, All Washington Counties



Note: Families enrolled in Medicaid have no out of pocket health care expenses.
Source: William M. Mercer, Inc.

Annual Health Care Expenses by Health Status: 2 Adults, 1 Infant, 1 Preschool-Aged Child, All Washington Counties



Note: Families enrolled in Medicaid have no out of pocket health care expenses.
Source: William M. Mercer, Inc.

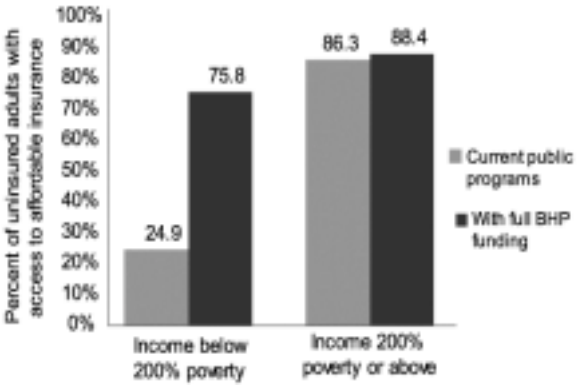
2. The Affordability Index

The affordability index built in this analysis is not an index of likelihood to purchase – it does not account for other priorities of the family, risk aversions, or attitudes about health insurance or health care. However, it does appear to discriminate quite well between those who do and do not have coverage: Among those who are insured, 91.5% are measured through this method as having access to affordable coverage. Among the uninsured, only 58.5% are measured to have access to affordable coverage (including public coverage). The index is also applied to examine how access to affordable coverage varies for children and adults, for those with access to employer coverage and without, and by health status (healthy, average or sick).

The affordability index reveals that access to affordable coverage varies by income, despite the existence of public insurance programs for the low-income. Only one in four uninsured adults with income at or below 200% has access to affordable insurance – largely because opportunities to enroll in public insurance are very limited for adults (e.g., Basic Health funding limits effectively limit access for additional numbers of uninsured adults to enroll.)

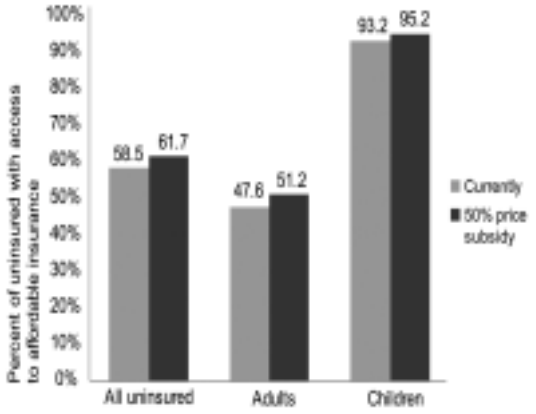
If assuming a subsidized program such as Basic Health were available without enrollment caps, over 75% of adults at or below 200% FPL could find affordable coverage with Basic Health or a similarly subsidized program.

Access Among Uninsured Adults to Affordable Insurance by Income, Current and With "Full Access" to Basic Health for All Eligibles, 2000



Source: 2000 Washington State Population Survey. Data refer to the under 65 population.

Access Among Uninsured Adults to Affordable Insurance, Current and With 50 Percent Premium Subsidy

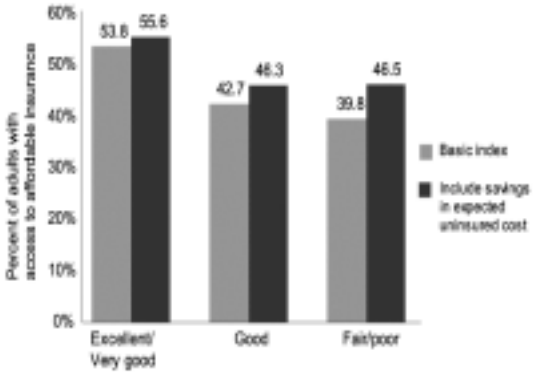


Source: 2000 Washington State Population Survey. Data refer to the under 65 population.

Access to affordable coverage also varies substantially between adults and children. Most children with family incomes below 250% FPL have access to affordable coverage through SCHIP, Medicaid or Basic Health. However, fewer than half of uninsured adults have access to affordable coverage. As discussed earlier public insurance programs are widely available for children, but few programs widely serve adults.

Estimation of the impact of a 50% subsidy to the cost of <u>private</u> insurance demonstrates only slight improvement in the numbers of uninsured that could afford to buy an individual insurance policy.[vi]

Access Among Uninsured Adults to Affordable Insurance by Health Status



Source: 2000 Washington State Population Survey. Data refer to the under 65 population – adults 19-64.

Access to affordable coverage also varies by health status – uninsured adults in poor health are least likely to have access to affordable health care coverage, reflecting higher premiums charged for high-risk cases as well as higher expected out-of-pocket expenditures. However, after factoring in an insurance 'savings' assumption that effectively lowers the overall out-of-pocket expenditures a person might experience with insurance vs. without, differences in affordability by health status diminish slightly.

The Translation Challenge:

Our remaining challenge is somewhat daunting --- to finish reviewing the technically complex findings to understand their implications for Washington, then translate the many income adequacy measurements into information relevant to current policy conversations. In general our findings show promise – conceptually they appear consistent with similar analyses conducted around the nation. It is our hope that once we have completed our review, other states for whom a *Self-Sufficiency Standard*[vii] has been developed will consider our model as an opportunity for advancing their own analyses of affordability. We are excited by the possibilities for applying the analysis to the crafting of future coverage and access strategies.

c. Marketplace Feedback:

The consultants held a focus group of insurance carriers – representatives of the largest carriers participated in a discussion of the health care marketplace and anticipated approaches to respond to market changes that they see coming. Some of the major points made in the discussions are highlighted below.

Where is the health care and health insurance marketplace going?

- A reversal of managed care cost-shifting practices (to providers of care) back to insurers to employers to plan participants.
- Movement by larger employers to self-insured plans due to the ability to design most benefit features to be responsive to their workforce demands. As well as movement by larger employers from local to national plans. (The participants suggested that local plans would no longer be competitive on issues of price or other features.)
- Limited movement to HMOs, particularly by individuals and small employers, because HMOs' rules and policy are viewed as restrictive, although they do help to manage care and costs. Because of the nature of the populations remaining in HMO plans, local HMOs will see a rise in bad risk.
- Elimination by national carriers of their HMO plans, because they cannot manage them and because they will need to eliminate "loss leaders."

- Continued "MTV style" health care marketing (specific lifestyle drugs, vision correction surgery, full-body scanning for "benchmarking" purposes rather than diagnosis)..

How are payers going to respond to the market changes?

The participants suggested that all payers are "spinning around" (looking around to get a more complete sense of changes and appropriate responses). One or more suggested that many of the following options would be considered:

- *Utilization/Demand Management:* including selected use of staff model HMO arrangements; evolution of other HMO plans into point-of-service plans requiring higher participant contributions toward premiums and higher cost sharing at time of service for out-of-network services; evaluation of services and procedures with regard to their effect on quality of life, and additional education about them; discontinuation of efforts to pre-authorize initial diagnostic visits to general and specialist providers, but stronger efforts to manage follow-up care and intervene in costly diseases; and education of consumers about providers' treatment outcomes (e.g., mortality rates) and costs.
- *Plan Design*: Limited benefit distillation, as is already being seen with prescription drug formulary use and cost sharing, emergency room visit copayments, etc.; there is also some interest in "leaner" products that might include very high deductibles, benefits that are all subject to the deductible, considerable cost-sharing with no out-of-pocket limits, and tighter medical underwriting.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

Methods:

Washington explored several separate (but related) efforts that will contribute to developing coverage options. We have taken a very methodical approach to our work and believe that selecting improvement strategies in the absence of data, education, and dialogue cannot be successful. The first phase of the work has focused on research and data analysis, in order to build the foundation for informed discussions. Each of these efforts is described below.

a. ***Coverage and Access*:** This analysis focuses on the strategies traditionally identified as options for improving coverage and access, e.g., employer buy-ins to public programs. Efforts here focused on rigorous analysis of the "universe of strategies", mapped to parallel approaches historically tried and/or currently in place in Washington State, culminating in an analysis of strengths and weaknesses, potential viability for implementation, and an initial review of estimated impact on uninsured populations identified in the profile analysis. The database of strategies was developed via literature reviews, environmental scans of other states' experiences (state level and otherwise; public and private), and expert opinion. A more detailed assessment of specific populations targeted by each strategy will be linked with findings of the profile analysis to build a basis for focusing priorities.

b. ***Administrative Simplification:*** This analysis focuses on identifying strategies for simplifying administration of the system, and identifying potential opportunities for private-public partnerships to cooperatively reduce the administrative costs of health care. The hypothesis is that simplification of the system will (1) reduce inefficiencies and redundancies, and thus contribute to slowing overall cost growth trends and (2) reduce the "hassle factor" for plans and providers, increasing the likelihood that they will continue to "play" in Washington's market. The baseline for identifying broad collaborative administrative efficiency efforts (and interests) is built with a detailed interview inventory with key informants and a technical advisory group. A literature review also identifies other private-public collaborative efforts that may provide lessons to Washington.

c. ***Community Initiatives:*** This effort focuses on identifying and describing local access initiatives, and assessing opportunities for the state to build partnerships with community-based access projects. The project includes an interest in identifying mutual understandings of the issues faced by communities and the state, solutions contemplated, and flexibility and accountability needed for success. There are four HRSA Community Access Program (CAP) grantees in Washington State plus numerous other community-based efforts, each focusing on access issues (some looking at systemic change; others focusing on immediate survival). The initial focus was on identifying alternative – more systemic - models of community-based delivery and financial flow arrangements that partner private and public purchasers with the local communities and their health care delivery systems. Methods included "informed expert" meetings (e.g., Washington Health Foundation, Communities that Won't Wait), targeted interviews with communities with follow up focus group/needs assessment discussions - to provide an overview of community efforts in Washington and provide the baseline information for assessing opportunities for collaborative partnerships and or technical assistance.

Findings:

The multi-disciplinary consultant team is just completing the initial research work, with finalization of research deliverables expected over the next two months. As a result, the initial research findings have not yet been fully assessed and analyzed for key messages. More in-depth analysis and refinement of the initial research will evolve as we have opportunity to reflect on the data. Broad-based discussions that will be built on this framework will also help identify areas needing further refinement and analysis, and guide interest in implementation opportunities.

a. **Coverage and Access:**

Research Phase: We have started the initial linking of the profile data and relevant policy options. Preliminary lessons that may be learned from the characteristics of the uninsured, and the related gaps and barriers to coverage, have been identified by the consultant team, and are highlighted below.

Gaps and Barriers in Coverage and Implications for Policy
(Excerpted from the draft consultant report on Profiles of the Uninsured)*

Gaps and Barriers:
The uninsured are found in all income groups, among all racial/ethnic groups, among the young and old, and in all areas of the state. Yet several characteristics of the uninsured are important for designing policy solutions.

- They are primarily low-income. More than two-thirds are in families with income at or below 200% of the federal poverty level (FPL), accounting for 308,000 uninsured people. And these individuals are more than twice as likely to be uninsured as those above 200% FPL. This is consistent with the analysis of income adequacy, which indicates that families that can meet their basic living expenses and have enough money left over to pay for out-of-pocket health care costs frequently have incomes higher than 200% FPL. Below 200% FPL, families often do not have enough resources to pay for insurance.

- The majority (53%) of the uninsured are adults without children.

- Children account for 25% of the uninsured. The uninsured rate for children is lower than for adults as a result of recent efforts to cover children, but 116,000 children still lack coverage in Washington. The overwhelming majority of these children also have uninsured parents.

- Most uninsured people (75% or 365,000) are workers or their dependents. However, there is substantial diversity in the work situation of these individuals. Over three-quarters of this group does not have access to employer-sponsored coverage, about 31% work for an employer that does not offer coverage, and about 46% are self-employed. Families whose employer-based options is at small group rates must generally have incomes greater than 250% FPL – in some cases, more than 300% FPL – to purchase this coverage and still meet their basic living expenses.

These coverage gaps suggest that policies to reach the uninsured population must overcome a number of barriers:

- Affordability of coverage is likely to be the foremost problem given that the uninsured are concentrated among low-income individuals. The analysis of affordability confirms it is a significant barrier: more than 50% of the uninsured adults lack access to affordable coverage.

- Many who lack access to affordable private coverage do not qualify for public programs. Childless adults are especially at risk given public program eligibility rules.

- When families without dependents have enough income to cover basic living expenses, they are not eligible for Medicaid. In two of the counties examined, families with two adults and no dependents are also not eligible for Basic Health if they have incomes high enough to meet their basic living expenses. Conversely, most families with dependents would be eligible for Basic Health, even with incomes high enough to meet their basic living expenses. Many of them are also eligible for Medicaid.

- Lack of full participation in public programs by those eligible suggests that not all barriers may be financial. Almost 20% of adults and 10% of children eligible for public programs are uninsured. Lack of knowledge of programs and their eligibility rules may be among the non-financial barriers.

- Lack of availability of family coverage may be a barrier to achieving a goal of insuring all children.

Policy Implications and Challenges:
Most policy options to expand insurance that are under serious consideration by states or at the Federal level are incremental in nature and can be classified in one of four major groups: options to build on the employer-based insurance system; policies to expand the voluntary purchase of individual coverage; public coverage expansions; and proposals that are aimed at specific population groups or at populations with specific needs – such as the uninsurable or those who have recently lost insurance after losing a job. The analysis points to a number of challenges for designing effective incremental expansions:

- Substantial premium subsidies are likely to be necessary for the success of any approach.
  The consultants found that price appeared to be a factor in employee decisions not to enroll in employer plans, especially for dependents, and that price appears to be a deterrent to employers offering coverage. However, quite substantial differences in price have only modest effects on take-up and offer rates. Similarly, large differences in price for coverage resulting from the tax treatment of insurance for the self-employed have only modest effects on insurance rates for the self-employed. Moreover, even with a 50% subsidy of premiums for available coverage, about 40% of the uninsured would not have access to affordable coverage.

- No one approach is likely to solve most problems; a combination of policies is likely to be necessary.
  Policies to make existing employer-based coverage more affordable would apply to only about 20% of the uninsured. Policies to encourage more employers to offer coverage would potentially benefit only about 25% of the uninsured. Policies to help those in job transitions may benefit some uninsured, unemployed individuals, but they account for about one-quarter of the uninsured population. Public programs to provide coverage at no cost are likely to be

necessary to reach the poorest of the uninsured – more than one-third of the uninsured have incomes below the federal poverty level.

- Effective targeting is a challenge in designing policies to expand the employment-based system.
  One-fifth of the uninsured do not participate in offered employer-sponsored insurance programs, but only a very small minority of employees, even among the low-income, who are offered coverage fail to participate.

- Expanded public program eligibility is likely to be necessary to close the gaps in coverage – especially expansions in coverage for adults.
  The largest group of the uninsured, childless adults, are currently ineligible for most public programs in the state. Some coverage is available for parents of dependent children, and broader options exist for children. However, the insurance status of the parent is a key predictor in the insurance status of children – most uninsured children have uninsured parents. Policies to extend eligibility for public programs to parents may be key to reducing the number of uninsured children.

- Further administrative simplification, outreach/marketing, and other policy changes may be necessary to reach the uninsured through public programs.
  Not all eligible individuals participate in public programs. Analysis suggests that a large share of people may not be aware of existing programs, or be confused about them. Program features that make it difficult to access programs may need to be redesigned to reach a full coverage goal.

- The uninsured population is best described as a flow rather than as a static pool. The changing nature of the uninsured populations poses a large number of challenges for effective policy design.
  Many people move in and out of being uninsured. About 70% more people are uninsured at some time during the course of a year than are uninsured at a point in time. Many of these people will have short-term gaps in insurance. However, the uninsured population at a point in time consists primarily of a large number of individuals who are chronically uninsured – about 75% will have been uninsured for one year or more.

**The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.*

Within the context of the Guiding Principles (see Appendix III, Section 5) established as a framework for the consultant team, the consultant's identified a vast range of individual policy options or strategies for rigorous research and analysis. The database of strategies was developed via literature reviews, environmental scans of other states' experiences (state level and otherwise; public and private), and expert opinion, including a panel discussion at a National Academy for State Health Policy (NASHP) conference. Options were chosen for analysis because they have been tried in Washington or elsewhere; they have been or are being considered seriously in policy circles at the local, state, or federal level; they have been evaluated by policy analysts or researchers; or they represent innovative models that the consultant team thinks may hold some promise.

The research efforts were grouped into five major categories of potential state actions that might expand coverage or enhance access. The options illustrate the spectrum of possibilities within each broad category— some that have been well tested in other places and some that are more novel, some that require a good deal of government intervention and others that do not. The categories and options are summarized below:

Snap-Shot of Coverage and Access Categories for Research

Category	Options
I. Financial incentives to individuals and families to purchase health insurance (Subsidies include vouchers, tax credits, and direct payments)	• Subsidies to assist low income in buying individual coverage • Subsidies to assist high-risk people in buying individual coverage • Subsidies or reforms for transitional coverage (e.g. COBRA) • Subsidies of employee contributions to employer-sponsored insurance
II. Financial incentives to employers to purchase health insurance for their employees	• Direct subsidies or tax credits to employers • Play or pay mandate on employers
III. Health insurance purchasing pools	• Employer-based purchasing pools • Individual or individual/small market purchasing pools • Other community-based purchasing pools • Mobile worker purchaser pools • Consolidated state funded pools
IV. Direct subsidies for safety net or charity care services (for those whom insurance may never seem like a viable option)	• Expand state's Community Health Services grant program • Create discount health cards for individuals • Expand federal health professional shortage areas (HPSAs) • Expedite rural Health Center designation • Increase payment to providers via health plan contracts • Tax credit for not-for-profit hospitals • Tax credit for physicians, physician assistants, and nurse practitioners • Uncompensated care pools
V. Insurance market regulations	• Relief from benefit mandates • Individual and small-group market regulations • High-risk pool expansion • Universal catastrophic coverage
VI. Public Program Expansions	See text below

Extensive discussions on public program expansions were not included in the consultant's research of general literature.[viii] In Washington the public insurance programs include a vast array of coverage options through Medicaid, SCHIP and the Basic Health program. The fact that public program expansion options are not extensively addressed in this venue does not reflect a value judgment regarding their worth; rather it reflects a practical reality in Washington that includes the following:

- Many of the expansion ideas have been implemented in Washington through Medicaid, SCHIP or Basic Health. Many states offer lower eligibility thresholds for their Medicaid and SCHIP programs, thus, proposals about expanding coverage often refer to increasing income eligibility (e.g., 200 percent) to levels already achieved in Washington. (See Section 3 for graphics depicting Washington's public program expansion efforts and eligibility thresholds.)
- Washington is actively pursuing a Medicaid waiver that would include modest expansions to populations not currently eligible (e.g., parents of currently eligible children). State and federal policy makers, program administrators, and low-income

advocates are jointly examining all possible avenues at a level of detail well beyond that captured in a general literature review.

- The Basic Health program offers a ready vehicle for serving the populations targeted in many expansion discussions (e.g. low-income adults not currently eligible for Medicaid), and in fact, a voter approved initiative (I-773 passed in the fall of 2001) authorized additional tobacco taxes for targeted support of health care programs like Basic Health. As a result, Basic Health will have an additional 47,000 enrollment spaces available by the end of the biennium (June 2003).[ix]

In addition to public program expansions, some other potential options were not included in the consultant's research:

- Approaches that entailed broad, comprehensive, statewide reform of the health care financing and delivery system—such as a single payer model—were deemed outside the guiding principles in part because of interest in incremental and voluntary approaches. However, an individual mandate for catastrophic coverage was included because this option has received attention from stakeholders and policy makers in recent months.
- Approaches that would require either a complete redesign of public health insurance programs or a major change in Washington's tax system were also excluded. For example, to apply medical savings accounts (MSAs) or defined contribution systems to Medicaid or Basic Health would require a plethora of state and federal statutory and/or regulatory changes as well as a complete shift in how the state manages these programs. A major incentive to promote MSAs is that the money in such an account is not taxed; however Washington would probably need to first create an income tax in order to provide this incentive to individuals -- Washington remains one of the few states in the nation without an income tax, and it does not appear likely one will be imposed in the near future.

The initial research work of the consultant team provides a foundation for the state's continuing analysis of opportunities to improve health insurance access. A key element of the research includes mapping potential strategies to approaches historically tried and/or currently in place in Washington State. A high level snapshot of the mapping thus far is attached below

The research of coverage and access options was conducted simultaneously with the analysis of the profiles of the uninsured. As a result, the mapping of strategies onto targeted populations is not yet complete. Further analysis and application of more detailed population gaps, and barriers to coverage will continue and an assessment of effectiveness and efficiency of particular strategies will be paired with value-based tradeoffs regarding the highest priorities for targeting (e.g., which groups should be of highest priority to address; should priority be determined by relative numbers, or relative barriers.)

Washington State Planning Grant on Access to Health Insurance

Summary Description of Policy Options Researched

(Excerpted from draft consultant report on Potential Policy Options for Enhancing Access to Health Insurance Coverage*)

		Target Population			
Option	**Option Description**	**Description**	**Gap Addressed by Option**	**Barrier Addressed by Option**	**Washington State Context and History**
I Individual/ Family Incentives					
1. Subsidies to assist low income in buying individual coverage	Provide tax credits (through federal programs), vouchers or other subsidies to assist low income individuals/families without employer-sponsored coverage to secure coverage	Low-income (<200% FPL) people and their families	Most (~65%)uninsured are low-income (<200% FPL) or 308,000 people. People with family income >200% FPL twice as likely to have employer coverage as low-income people.	More than half of uninsured adults and one in ten uninsured children lack access to affordable private coverage. 75% of uninsured, low income adults do not have access to affordable coverage.	BH/BH Plus expanded statewide (1993) to subsidize coverage for low-income people. Established SCHIP(2000) to expand eligibility for publicly subsidized coverage w/ premium and co-payment cost sharing for children in families with incomes between 200%-250% FPL.
2. Subsidies to assist high-risk people in buying individual coverage	Subsidize premiums for individuals with high expected or actual medical costs through Washington State Health Insurance Pool (WSHIP or "high risk pool")	People with high expected or actual medical costs who are unable to obtain private coverage through the individual market	People in fair/poor health have twice the rate of uninsurance (15%) as those in excellent or very good health (6.8%).	About 60% of uninsured adults in fair/poor health do not have access to affordable coverage. Very limited or no other coverage available for people screened out of individual market.	WSHIP created in 1988 to serve medically uninsurable. Funded via assessments on insurers, stop-loss and re-insurance carriers, and limited enrollee premiums. As of 1999, about 1,900 enrolled in WSHIP, about 0.3% of individual market.
3. Subsidies or reforms for transitional coverage (e.g., COBRA)	Subsidize COBRA premiums for individuals and their families during employment transitions	People in employment transition and their families. COBRA subsidies target an estimated <11% of uninsured and <13% of low-income uninsured.	Nationally, 2/3 of uninsurance episodes begin w/ loss of employer sponsored coverage. About 25% of Washington's uninsured are unemployed - half of these recently lost a job or are looking for work.	Only about 20% of COBRA eligible workers buy coverage, primarily due to cost. These 20% tend to be sicker and incur higher claim costs than those who remain covered by employer. Individual market options also not affordable. BH enrollment caps may limit access to more affordable, subsidized coverage.	Federal COBRA laws require employers with more than 20 employees to offer health coverage to all employees who quit or lose their jobs; employees must pay 102% of the group premium. Washington does not have regulations that require smaller employers to offer such coverage (as in 38 other states).

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		Target Population			
Option	**Option Description**	**Description**	**Gap Addressed by Option**	**Barrier Addressed by Option**	**Washington State Context and History**
4. Subsidies of employee contributions to employer-sponsored insurance.	Provide contributions to employer-based coverage for those with low-incomes	Low-income uninsured with access to employer-sponsored coverage	People with family income >200% FPL twice as likely to have employer coverage as low-income people. Some uninsured (18% of all uninsured and 13% of low-income uninsured in 2000) had access to, but did not elect, employer-sponsored coverage.	20% of people with access to employer-sponsored coverage unable to afford coverage.	Basic Health offers limited program for employers to pay employee BH premiums if the firms meet participation and enrollment criteria. Medicaid's Health Insurance Premium Payment (HIPP) program subsidizes limited enrollment in employer-sponsored coverage for Medicaid-eligible people and their families. HIPP enrollment limited by complex administrative requirements and limited eligibility for uninsured adults.
II. Employer Incentives					
1. Voluntary subsidies to employers	Provide subsidies or tax credits to small business or other targeted employers to reduce price of coverage and expand number of employers offering coverage. Most existing subsidies in other states target small businesses.	Some types of businesses less likely to offer employee coverage. Small businesses (9.5-11.4% of all uninsured people and 23-28% of uninsured workers), low-wage businesses (2.7-3.6% of all uninsured and 6.7-8.9% uninsured workers) and businesses with high percentage of part-time workers least likely to offer coverage.	Employers more likely to offer coverage as firm size increases. Small business workers least likely to be offered coverage - 54% of small-business workers vs. 92% of large businesses (>50 employees). About 65% of businesses with high percentages of part-time or seasonal workers likely to offer coverage vs. 82% of other businesses. About 61% of low-wage businesses offer coverage vs. 85% of other businesses.	Half of all adult workers or their adult dependents who are not offered employer coverage do not have access to affordable coverage. Limited access to affordable enrollment for low-income through BH also restricts affordable alternatives.	In 1993 BH employer program implemented to subsidize employee premiums for eligible Few employers currently enrolled, and the program is currently very limited.
2. Play or pay mandate on employers	Require firms to offer coverage or pay payroll tax to support public coverage program	Uninsured workers and dependents without access to employer-sponsored coverage.	20% of workers do not have access to employer coverage. 23% of uninsured are workers/dependents without access to employer-sponsored coverage.	Half of all adult workers or their adult dependents who are not offered employer coverage do not have access to affordable coverage. Limited access to affordable enrollment for low-income through BH also restricts affordable alternatives.	An employer mandate was passed by the Washington State Legislature in 1993, but was repealed in 1995 before being implemented.

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		Target Population			
Option	**Option Description**	**Description**	**Gap Addressed by Option**	**Barrier Addressed by Option**	**Washington State Context and History**
III. Purchasing Pools					
1. Employer-based purchasing pools	Pooled and centrally administered purchasing of health care coverage on behalf of, or by, businesses to: (1) obtain lower costs through volume purchasing and spread risk, (2) reduce costs by centralizing administrative functions and improving negotiating power with providers, and (3) promote price/quality competition among participating plans, and (4) increase choices available to individuals, families and participating groups.	Uninsured workers in businesses that are less likely to offer coverage - e.g., small or low-wage businesses.	Small businesses less likely to offer coverage - 54% of small business workers and 61% of workers in low-wage businesses offered coverage vs. 92% of large business workers (>50 workers).	Premium costs for small businesses not offering coverage predicted to be higher than actual premium costs for those offering coverage. Small group premium costs higher than large group.	Several pooling arrangements exist in Washington, primarily as employer pools, such as the Washington Counties Insurance Fund, Employers Health Purchasing Cooperative, Association of Washington Businesses. Also available through self-insuring mechanisms.
2. Individual or individual/small market purchasing pools	Same as above, but for individuals and/or small groups	Low-income (<200% FPL) people and their families without access to public or employer-sponsored coverage; uninsured workers in businesses that are less likely to offer coverage such as, small or low-wage businesses.	Most uninsured (~65%)are low-income (<200% FPL) or about 308,000 people . People with family income >200% FPL twice as likely to have employer coverage as low-income people.	More than half of uninsured adults lack access to affordable private coverage and one in ten uninsured children lack access to affordable coverage. Only 25% of adults with income <200% FPL have access to affordable coverage. 20% of people with access to employer-sponsored coverage unable to afford coverage.	BH/BH Plus - state subsidized and unsubsidized health insurance purchasing pools for low income individuals and certain businesses; WSHIP - high risk insurance pool for individuals who cannot afford private individual coverage

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		Target Population			
Option	**Option Description**	**Description**	**Gap Addressed by Option**	**Barrier Addressed by Option**	**Washington State Context and History**
3. Other community-based purchasing pools	Same as above, but pooling based on characteristics other than employment, such as residence in particular community.	Communities with higher rates of uninsurance or higher likelihood of being uninsured. Communities that seek to develop new pooling arrangements.	Rural, particularly Eastern, Washington has higher rate of uninsurance than urban areas. Most uninsured live in Western Washington urban areas. Native Americans/Alaskan Natives (27.9% uninsured) and Hispanics (22.6% uninsured) have the highest rate of uninsurance. Existing insurance pools tend to fragment risk into low and high groups, resulting in some people being unable to obtain or afford coverage.		Several Washington communities and groups developing or considering alternative mechanisms to assure access to insurance coverage and health care services for their members. Examples include the Spokane Health Insurance Partnership, the Jamestown S'Klallam Managed Care Program, and the CHOICE Regional Health Network. See Report 4.4 *Community Access Initiatives*.
4. Mobile worker purchasing pools	Same as above, but for workers who frequently change employers.	Working uninsured in certain industries with high mobility (e.g., construction, wood products, retail), seasonality (agriculture), or high use of part-time or temporary/contract workers (e.g., health care, high technology).	Likelihood of employer-sponsored coverage availability varies by industry, seasonality, and firm size. Coverage offered to 63% of employees in seasonal businesses and 65% of employees in predominantly part-time businesses vs. 81% of employees in non-seasonal businesses.	About 51% of uninsured adults without employer coverage do not have access to affordable private coverage. Limited access to affordable enrollment for low-income through BH also restricts affordable alternatives.	Pools exist in selected industries (e.g., wood products, construction) through Multiple Employer Welfare Arrangements, union or Taft-Hartley trusts.

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		Target Population			
Option	**Option Description**	**Description**	**Gap Addressed by Option**	**Barrier Addressed by Option**	**Washington State Context and History**
IV. Direct Safety Net Subsidies					
1. Expand HCA Community Health Services Grant Program	Expand HCA's Community Health Services (CHS) grant program with funds distributed according to number of uninsured served by clinics.	Uninsured w/ family incomes <200% FPL.	Most uninsured (~65%) are low-income (<200% FPL), about 308,000 people . High unemployment rates (7.5% in Jan. 2002) correlated with higher uninsurance rates - 18.5% of uninsured in families without employment vs. 11.5% w/ one employed family member and 3.8% w/ 2 employed family members. More state residents experience transitory episodes of uninsurance during a year (15.5%) than at a point in time (9.2%).	About 25% of adults and 10% of children lack access to affordable coverage, suggesting difficulty accessing affordable health services. Uninsured rates higher in rural areas, particularly Eastern Washington, raise issues of access to affordability and ability to pay and associated financial viability concerns from providers in communities with limited or no access to safety net providers.	Health Care Authority administers CHS grant program that provided $6m in funding in 2000. CHS grants provided 26.7% of total clinic funding to partially support 341,000 medical clients and 114,000 dental clients served by 29 community-based organizations. In 2000, 29% of Washington Association of Community and Migrant Health Centers (WACMHC) clients were uninsured and paid sliding scale fees. Bush administration funding Health Centers Initiative to add or expand 1200 CHC sites across the US over five years and double the number treated (expect half to be uninsured). As of Jan. 2002, this initiative provided $14.6 million to 60 grantees, including Community Health Association of Spokane ($133,333).
2. Create discount health card for individuals	Create program for low-income uninsured to purchase a discount card that enables them to obtain care from participating providers. May partner with local communities or local provider networks to pilot discount card approaches. May use Community Health Services grantees or investigate feasibility of using UMP preferred providers as provider network.	Uninsured w/ family incomes <200% FPL.	Most uninsured are low-income (<200% FPL) - about 65% or 308,000 people . Rural, particularly Eastern Washington, has a higher rate of uninsurance and more limited access to CMHC/RHC services than urban areas. Certain populations are more likely to be uninsured - particularly Native Americans/Alaskan Natives (27.9% uninsured) and Hispanics (22.6% uninsured).	About 25% of adults and 10% of children lack access to affordable coverage, suggesting difficulty accessing affordable health services. Uninsured rates higher in rural areas, particularly Eastern Washington, raise issues of access to affordability and ability to pay and associated financial viability concerns from providers in communities with limited or no access to safety net providers.	No specific history with discount cards, although one Central Washington community is exploring the idea. Pilot projects in early development in Arizona and Hawaii.

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		Target Population			
Option	**Option Description**	**Description**	**Gap Addressed by Option**	**Barrier Addressed by Option**	**Washington State Context and History**
4. Expedite Rural Health Center (RHC) designation	State provides technical assistance to physician practice staff in applying for RHC designation.	Low income uninsured in rural areas.	Rural, particularly Eastern Washington, has a higher rate of uninsurance than urban areas raising issues of access to affordability and ability to pay. Rural areas have fewer safety net providers, leaving the burden to private health care practices.	Uninsured with family income <200% FPL most dependent on availability of providers willing to offer charity care.	State Department of Health (DOH) estimated that federal HPSA designation allowed local clinics, providers, and health jurisdictions to qualify for $35 to $50 million in federal funds. 70 health care practices are certified RHCs, 35 pursuing certification (as of 12/01). Federal government RHC surveys are currently low priority.
5. Increase payment to providers via health plan contracts	Increase premiums to State-contracted health plans (BH, PEBB, Healthy Options) that then increase payment to providers who expand services to uninsured.	Uninsured w/ family incomes <200% FPL.	9.2% of Washingtonians uninsured. Most uninsured are low-income (<200% FPL) - about 65% or 308,000 people .	About 25% of adults and 10% of children lack access to affordable coverage, suggesting difficulty accessing affordable health services. Uninsured with family income <200% FPL most dependent on availability of providers willing to offer charity care.	None.
6. Tax credit for not-for-profit hospitals	Extend B&O tax credit to not-for-profit hospitals. Tax credit tied to number of uninsured served or percentage of revenues used for charity care.	Uninsured w/ family incomes <200% FPL.	9.2% of Washingtonians uninsured. Most uninsured are low-income (<200% FPL) - about 65% or 308,000 people .	About 25% of adults and 10% of children lack access to affordable coverage, suggesting difficulty accessing affordable health services. Uninsured with family income <200% FPL most dependent on availability of providers willing to offer charity care. From 1996 to 1999, hospitals incurred increasing total charges for charity care.	In 1993, Legislature removed B&O tax exclusion for not-for-profit and public hospitals and required B&O tax on non-governmental revenue to fund BH expansion.

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		Target Population			
Option	**Option Description**	**Description**	**Gap Addressed by Option**	**Barrier Addressed by Option**	**Washington State Context and History**
7. Tax credit for physicians, physician assistants, and nurse practitioners	Offer B&O tax credit to physicians, physician assistants and nurse practitioners (or their business entities) who provide care for the uninsured.	Uninsured w/ family incomes <200% FPL.	9.2% of Washingtonians uninsured. Most uninsured are low-income (<200% FPL) - about 65% or 308,000 people .	About 25% of adults and 10% of children lack access to affordable coverage, suggesting difficulty accessing affordable health services. Uninsured rates higher in rural areas, particularly Eastern WA, raising issues of access to affordability and ability to pay and associated financial viability concerns from providers in communities with limited or no access to safety net providers.	No specific history with B&O tax credits for providers.
8. Uncompensated care pools	Set up uncompensated care pool to enhance revenues for hospitals or other providers who provide disproportionate share of services for uninsured. Two options: (1) Internal financing - hospital charity care resources pooled and funds distributed from pool to hospitals based on proportion of charity care provided, and (2) External financing - Funded from outside revenue source, such as dedicated tax, and distributed based on charity care provided (number of patients or percentage of revenues).	Uninsured w/ family incomes <200% FPL.	9.2% of Washingtonians uninsured. About 65% of uninsured (308,000) have family income <200% FPL. Demand for hospital-based charity care increased by 10.4% (from $102 million to $112 million) between 1997 and 1999. Hospital-based charity care as percentage of total revenue declined from 3.2% in 1996 to 2.2% in 1999. 19 of the state's 90 hospitals provided 76% of hospital-based charity care in 1999. Rural hospitals provide less charity care (as % of total adjusted revenue) than urban hospitals.	About 25% of adults and 10% of children lack access to affordable coverage, suggesting difficulty accessing affordable health services.	1983/84 - Policy makers considered developing an internally financed hospital charity care pool. Effort did not generate sufficient political momentum and was not implemented.

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		Target Population			
Option	**Option Description**	**Description**	**Gap Addressed by Option**	**Barrier Addressed by Option**	**Washington State Context and History**
V. Regulatory and Market Reform					
1. Relief from benefit mandates	Reduce or eliminate state requirements that insurers cover specific services or types of providers	People in individual, small-group (<51 employees) , and large group insured markets	Some concerned that benefit mandates reduce access to affordable coverage, especially for small businesses and their employees. 40% of workers in small-group businesses and about 25% of these are uninsured. About 6% of state residents in individual market. About 9.2% of WA residents are uninsured.	Fewer than half of uninsured adults have access to affordable coverage.	Washington State has 22 mandated benefit laws -- 10 affect group coverage, 12 affect both individual and group products. Mandates include coverage for specific services, access to certain licensed providers, administrative mandates governing eligibility or rules for continued coverage. In early 1990's, OIC began authorizing "value" health insurance products by exempting some small group products from benefit mandates. Value products experienced very low demand.
2. Individual and small-group market regulations	Restructure distribution of risk in individual and small-group markets	People in individual and small-group markets	40% of workers in small-group businesses and about 25% of these are uninsured. About 6% of state residents in individual market. About 9.2% of WA residents are uninsured.	More than half of uninsured adults do not have access to affordable private coverage. 93% of children have access to affordable coverage due to eligibility for public programs.	With exception of community rating bands, Washington regulations similar to other states but not linked across individual and small-group markets. After insurance market reforms of early 1990s, individual market marked by instability and declining access in areas of the state. Health Insurance Reform Act passed in 2000 to attract insurers back into individual market by allowing screening out 8% of highest risk applicants. Some plans re-entered market but premium rates have not declined.
3. High-risk pool expansion	Modify the state high risk pool to remove more people with high-risk medical conditions from the private individual or small-group markets.	People with high expected or actual medical costs who do not qualify for individual or small-group coverage.	People in fair/poor health have twice the rate of uninsurance (15%) as those in excellent or very good health (6.8%).	About 60% of uninsured adults in fair/poor health do not have access to affordable coverage. Very limited or no other coverage available for people screened out of individual market.	Washington State Health Insurance Pool created in 1988 to serve medically uninsurable. Funded via assessments on insurers, stop-loss and re-insurance carriers, and limited enrollee premiums. As of 1999, ~1,900 enrolled, ~0.3% of individual market.

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		Target Population			
Option	**Option Description**	**Description**	**Gap Addressed by Option**	**Barrier Addressed by Option**	**Washington State Context and History**
4. Universal catastrophic coverage	Provide mandated access to high-deductible, low-cost catastrophic coverage for all Washington residents.	All Washington residents not enrolled in Medicaid, Medicare, or other federal programs	9.2% of WA residents under 65 uninsured. 25% of uninsured are workers and dependents without access to employer-sponsored coverage. 15% of those in fair/poor health are uninsured, over twice the rate of people in excellent or very good health (6.8%).	Slightly less than half of uninsured adults and 10% of children lack access to affordable coverage. 75% of uninsured adults with income <200% FPL have access to affordable coverage. 20% of workers with access to employer-sponsored coverage unable to afford coverage.	Some policy-makers proposing examination of universal catastrophic coverage as potential option to address lack of access to affordable insurance.

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Beyond the Research: A preliminary workshop of self-selected stakeholders --30 total -- discussed the targeting of tradeoffs and potential priorities as part of an annual health policy conference.[x] Five discussion groups were provided a brief overview of Washington's uninsured, and a discussion guide with specific questions on high priority groups, criteria to be used, and most viable options to serve priority groups. (Our Small Group Discussion Guidelines are attached in Appendix III, Section 5.) Similar themes arose from the five groups, including their interest in financial information to guide the tradeoffs, and a general agreement or interest in looking for the "biggest bang for the buck" – covering the most people was perceived by many to provide this, while one group noted return on investment also meant focusing on prevention and avoiding future illness costs to the system. When brought together, the five groups began focusing priorities on the largest demographic group of uninsured (19-34 year olds); the working uninsured; indigent; and all children. The group began to endorse a consensus that there were no magic bullets – in the absence of a more systemic approach to providing health care access, a variety of approaches would need to be patched together.

As part of the same health conference, a brief online survey of the conference attendees netted some preliminary feedback on viable strategies. Questions pertaining to the grant and the top three survey responses are below.

EXCERPTS FROM 2001 WASHINGTON HEALTH LEGISLATIVE CONFERENCE

Survey Results

Q12: In terms of improving access to health insurance, which reform proposals would be the most ***effective***?

- Create program of universal coverage for catastrophic or preventive care 44.0%
- Reform the insurance market 16.1%
- Broaden existing public program eligibility and/or financing 12.8%

Q13: Which proposals would be the most ***politically viable***?

- Provide new financial incentives for employers to help employees 22.7%
- Provide new financial incentives for individuals/families to purchase plans 18.7%
- Encourage development of new or maximize existing purchasing pools 18.0%

Q14: Which segments of the uninsured population should be targeted for help?

- All segments should be treated equally 34.1%
- Individuals working in low wage industries 30.1%
- Low income children 30.1%

Additional survey results are available in Appendix III, Section 5.

These preliminary discussions on target populations and potential strategies provide a glimpse into the challenges of the second phase of the grant - building consensus through broad-based discussions on the health care system. The work of the grant will provide a key building block for moving discussions forward, but there are many simultaneous efforts and discussions 'popping up' across the state, that will also provide potential for synergy, as well as friction. It is currently envisioned that a health care council will be jointly developed and chaired by the Governor and the independently elected Insurance Commissioner, as a forum for exploring

health care issues. The research of the grant is expected to become a foundation for data-focused conversations, and in turn the broad-based input will guide the refinement of the grant's work on specific strategies to improve access.

b. **Administrative Simplification:**

Research Phase: The initial research efforts were focused on identifying broad collaborative administrative efficiency efforts (and interests) of the private sector, with an eye towards identifying potential private-public partnerships to cooperatively reduce the administrative costs of health care. The detailed interview inventory of key informants revealed areas of interest to the private sector for simplifying administration of the system – that might help avoid unnecessary costs and reduce provider burdens.

The targeted interviews revealed few broad initiatives were actually underway. However many organizations are streamlining business practices under their direct control in areas such as development of electronic claims transactions and eligibility/enrollment processing, HIPAA guidance and training, on-line appointment systems, and Virtual Private Networks for secure communication across multiple locations.

One unique collaborative effort of the top insurance carriers, the hospital association, and medical association, among others, has made great strides in identifying and prioritizing key administrative hassles that could streamline business functions for 13 prioritized areas. This collaborative effort appears to provide a promising opportunity for a private-public partnership (with the state) that could offer meaningful streamlining of business processes across the industry.

The CEO Forum, established in 1998, is composed of the major private insurance carriers and providers of care in Washington State. This coalition of competitors has agreed to cooperate and share knowledge (within legal limits) for the good of the health care system and patients throughout the state. The Forum established a Network Advisory Group (NAG) in 1999 and the Administrative Simplification Steering Committee (ASSC) in 2000 to identify and address opportunities to simplify the administration of health care. In March 2001, the forum took another large step and formed Washington Healthcare Forum Services (WHFS), a corporation with initial funding from the Washington State Hospital Association, the Washington State Medical Association, and the four major health plans in the state: First Choice Health, Group Health Cooperative, Regence Blue Shield, and Premera Blue Cross.

The Forum has separated the technology-centered activities from the administrative process identification and improvement opportunities. The ASSC has identified opportunities for process improvement, especially standardization of processes, which may or may not include a technology component. The top three initiatives (referrals and preauthorization streamlining; claims processing; and credentialing) are moving forward with draft guidelines out for broad discussion. The Network Advisory Group is focused on electronic solutions for exchanging information between health plans and providers – and is moving forward exploring data and transaction standards, and standard, secure connectivity and access.

The two matrices below provide a summary description of administrative initiatives revealed in the inventory, and a summary of the CEO Forum priority initiatives.

Washington State Planning Grant on Access to Health Insurance

(Excerpted from draft consultant report on Administrative Simplification Initiatives) *

Summary Descriptions of Private Sector Administrative Simplification Initiatives

Administrative Simplification Initiative or *Issue*	Organization(s)of interest	Scope (geographic, subpopulation, etc.)	Description	Purpose(s) and/or Expected Outcome(s)
Structured approach to multiple administrative simplification projects	Administrative Simplification Steering Committee (ASSC) of the CEO Forum	Multiple payers and provider organizations in the private sector serving patients from private and public programs	The ASSC has engaged the major players in the private sector in an analysis and approach to simplifying administrative processes. See Attachment **XX** for a full description of the ASSC initiatives.	Standardization of business processes and improved health care delivery throughout the state
Secure electronic communications	Washington Health Forum Services (WHFS) Network Advisory Group (NAG)	The private health care sector in Washington State	WHFS has begun an initiative to establish secure communications across their member organizations	A platform for multiple future electronic applications to include claims transactions, eligibility, and enrollment
Identification of administrative issues for rural health care organizations	Choice Regional Health Network	Rural health care organizations in central, western Washington	As part of a larger grant project, Choice identified issues of concern to rural health care operations. See Attachment Y for more details	First step in addressing administrative issues of concern to rural health care operations
Pointshare VPN & Products	Community Choice	Within organization	Community Choice contracts with Pointshare for secure electronic communications and multiple products to streamline administrative processes, including enrollment and eligibility	Greatly increased efficiency
Electronic Claims transmission	ComPASS and others	Within and across organizations	Several organizations are developing their own internal electronic claims capability	Reduced denial of claims and improved cash flow
VPN/Secure communications	Inland NW Health Services	Within the 28 facilities of the INHS organization	INWHS has built its own VPN for secure communications across their health care delivery network. It securely processes electronic claims and checks eligibility and enrollment.	Increased efficiency of business processes and reduction of resource consumption
Secure communications	Medicare-Noridian, Community Health Plans of Washington, Community Choice	Washington State	Several organizations expressed a desire for secure electronic communications	The ability to process electronic claims, eligibility, and enrollment and other business in a secure environment is expected to improve care delivery and reduce costs
New partnership model	Choice Regional Health Network	Public-private collaborations	Choice is exploring new ways of interacting with the state that would be more collaborative and less competitive	Improved way to interact and understand across the sectors
HIPAA implementation	Choice Regional	Small, particularly rural, health	Choice is developing standardized approaches	Meeting implementation deadlines with minimal pain

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Washington State Planning Grant on Access to Health Insurance

(Excerpted from draft consultant report on Administrative Simplification Initiatives) *

Summary Descriptions of Private Sector Administrative Simplification Initiatives

Administrative Simplification Initiative or *Issue*	Organization(s)of interest	Scope (geographic, subpopulation, etc.)	Description	Purpose(s) and/or Expected Outcome(s)
	Health Network	organizations in central, western Washington	and assistance for HIPAA implementation at small health organizations	and resource expenditure.
Electronic medical record	Community Health Plans of Washington	Within organization and beyond	CHPW has commissioned an Information Technology Task Force to look at EMR possibilities	Patients can receive care anywhere and access health care with documentation available.
Enrollment and eligibility	Community Health Plans of Washington	Within its organization or entities serving its beneficiaries	CHPW provides consulting services and financial support to improve patient eligibility determination and enrollment	Greatly increased enrollment and reduced denial. Improved access and treatment.

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Washington State Planning Grant on Access to Health Insurance

Administrative Simplification Priorities of the CEO Forum – Administrative Steering Committee and Network Advisory Group

(Excerpted from draft consultant report on Administrative Simplification Initiatives) *

Opportunity	Description	Simplification Impact	Suggested Ideas	Comments
Streamline Referrals & Pre-Authorizations	Agree upon standard procedures for: Submitting requests to health plans for referrals and pre-authorizations Retrieving authorization information about submitted requests	Decrease time spent communicating referral information Improve experience of patient and consulting caregiver Reduce pending and denied claims (reduce timeframes of later steps)	Agree upon definitions and semantics (pre-auth, pre-cert, referral, authorization vs. payment guarantee). Agree upon a common 'short list' of services that require authorizations (or every plan could have their own very short 'short list') Auto adjudicate these services whenever possible. Agree upon common data elements and a standard submission and notification process. (Ideally, plans will accept the different forms that are generated by the different practice management systems as long as they contain the standard data set.) Develop guides about the process for education purposes. This would include who do providers call for what and which plans require. authorizations and which don't. Agree upon timeframe expectation for how long processing will take	Referral may be easier to auto-adjudicate than pre-authorizations
Standard Adjudication Logic	Agree upon standard guidelines/edits for adjudicating claims	Increase cash flow to providers Reduce time providers spend figuring out what to send to each plan and tracking it down	Agree upon standard criteria and procedures for pending and/or denying claims (e.g. CCI, etc.) Educate providers about the pending process Disclose proprietary edits Process secondary claims in a standard manner Implement a standard case rate methodology for outpatients	A possible win for plans if the number of appeals are reduced. Improvement ideas need to be carefully selected and defined. Information system changes may be an impediment. Focus should be on processes.

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Opportunity	Description	Simplification Impact	Suggested Ideas	Comments
Single Source Credentialing	Develop and implement a single, standard credentialing application and process that will be used by providers and health plans	Reduce time physicians spend completing forms Reduce time health plans and hospitals spend going through the process of credentialing physicians Save printing and mailing costs	A "quick-win" may be for plans to accept claims from approved providers as of 'credentialing submission date' rather than 'credentialing approval date.' Providers would hold claims until approval, then submit and be entitled to payment retroactive to the submit date. Endorse application developed by Washington Credentialing Standards Group (WCSG) Endorse work underway by WCSG to agree upon and implement a process and infrastructure for managing credentialing information at a single point Standardize requirements for which provider types need credentialing	Work on timeliness of processes first. Single source could be later. Consolidate with the Provider Directory Opportunity
Electronic Remittance Advice	Implement an electronic process for exchanging remittance advice information	Reduce time provider spend posting remittance information into their information systems		Smaller hospitals and smaller physician practices may not have necessary technology HIPAA has guidelines for implementing the electronic transactions
Streamline Case Management Process and Utilization Review	Agree upon standard procedures for managing inpatient cases and communicating authorization information in a timely manner.	Reduce time hospital staff spends trying to get services authorized	Publish authorization criteria Publish authorization expectations related to issues such as medical necessity Agree upon process and timeframe for communicating what is authorized.	
Standard Appeals Process	Agree upon standard procedures for handling and communicating information about claims that have been pended or denied.	Increase cash flow to providers Reduce time providers spend following up on previously submitted claims	Standardize what information is necessary to appeal, what are filing timeframes, etc. Plans disclose their procedures about what information is needed and why	Win for providers. May be a quick win to implement. Smoother front-end processes may lead to fewer back-end denials. In that case this would become of less importance
Comply with HIPAA	Develop common approaches for meeting HIPAA requirements, e.g.		Reach consensus on priorities for working together	

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Opportunity	Description	Simplification Impact	Suggested Ideas	Comments
	privacy policies, business associate agreements, electronic identifiers.		together Coordinate closely with NAG	
Standard Benefit Descriptions	Agree upon standard benefit descriptions that will be used by all health plans.			
Standard Audit Procedures	Agree upon a standard process for how health plans will audit clinical records that are maintained by providers. This includes expectations about how much notice of the upcoming audit will be provided, length of time to conduct the audit, and timeframe to communicate audit results.		Could a single time be set aside to do audits for all plans Transaction audit – plans review chart documentation related to specific event(s) Non transaction audit – plans review chart documentation to assess quality of clinical process (as defined by HEDIS, credentialing requirements, etc.)	
Standard Formulary	Develop a standard formulary. This may be a master formulary (compilation of the different formularies used by the various plans) or a common formulary (one formulary used by all plans).		Republish the "parallel" formulary (AWHP) which lists the various plans' formularies side-by-side within a drug class	Very big issue and difficult to solve
Standard Patient Communication	Develop communication materials that can be distributed to patients that will answer common questions related to eligibility coverage, benefits, referral procedures, case management process and general terminology.		Standard materials for patients and "road show" to providers	
Standard Insurance Card	Agree upon a standard for what information will be printed on an insurance card and how it will be displayed (e.g. health plan, program, billing address, contact information, PCP, physician network)		Find affordable ways for providers to get correct information about a patient's insurance coverage.	Some plans moving away from issuing cards The Blue plans have formatting standards
Single Provider Directory	Develop and keep current a provider directory that is accessible by providers and health plans			Consolidate with Single Source Credentialing

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Additional research: In addition to gathering information on Washington specific activities, a literature review identified additional collaborative models that provide useful models for Washington to consider. Models include:

- The Utah Health Information Network (UHIN) – a project focused on electronic network linking of the health care community, a statewide data repository, and standardization of health care transaction and reporting, electronic interface development and communication services.
- The Minnesota Center for Healthcare Electronic Commerce (MCHEC) focus on secure methods of encrypting and moving data electronically.
- The Western Governors' Association pilot demonstration of smart card technology in its Health Passport Project (HPP) being conducted in North Dakota, Wyoming, and Nevada. The HPP cards are designed to manage data and benefits from a variety of public health programs including: Head Start; Women, Infant, and Children; Medicaid; immunizations; and other maternal and child health services.
- The Coalition for Affordable Quality Healthcare proposal to develop a single source credentialing system using a nationwide database to reduce the overhead of the credentialing process for providers and payers.

Beyond the Research: The initial research efforts, focused on identifying broad collaborative administrative efficiency efforts and potential private-public partnerships, revealed interesting models for the state's consideration. The broad private sector collaborative effort of the CEO Forum and the Washington Healthcare Forum Services (jointly referred to as the Forum) offers an opportunity for partnership, as well as a model for the state to consider. However, a common theme expressed in the research needs to be addressed before a partnership can be effective - interviews revealed some hesitancy in 'partnering' with the state unless the state can organize the many voices expressed by multiple programs (e.g., Medicaid, Basic Health, Public Employees) in a coherent joined –"collaborative". This opportunity, as well as other interest areas identified in the initial research phase, will be explored further with the project's Management Oversight Panel, state agencies, and in other broad-based discussions as warranted.

c. **Community Initiatives:**

Research Phase: As originally conceived, this project component sought to identify community-based access initiatives, and assess opportunities to build partnerships between the state and communities. Efforts focused on targeted interviews with communities, and follow-up focus group/needs assessment discussions.

There are four HRSA Community Access Program (CAP) grantees in Washington State plus numerous other community-based efforts, each focusing on access issues (some looking at systemic change; others focusing on immediate health care needs). The initial focus of the State Planning Grant was on identifying alternative – more systemic - models of community-based delivery and financing that partner private and public purchasers with the local communities and their health care delivery systems. Each of the four CAP grantees was included in the overview, as were four other community efforts in Washington, and two out-of-state models that provide illustrations of the kinds of broad efforts underway across the nation. The summary description of targeted community initiatives is below.

Washington State Planning Grant on Access to Health Insurance

Summary Descriptions of Targeted Community Access Initiatives

(Excerpted from draft consultant report on Community Access Initiatives) *

Community Access Initiative	Lead Organization(s)	Scope (geographic, subpopulation, etc.)	Description	Purpose(s) and Expected Outcome(s)	Funding
Colville Tribe / Grand Coulee Hospital Collaboration	Grand Coulee Hospital District / Colville Tribe, North Central Washington	Residents of the Grand Coulee Hospital District (Douglas, Grant, Lincoln, and Okanogan, counties) and the 7,933 members of the Colville Tribe.	Planning to replace the existing hospital and nursing home; Tribe would supply capital, district would operate the facilities.	Improved access and service quality for Tribal members and district residents.	Internal
Community Choice HealthCare Network	Community Choice (Wenatchee)	Un- and underinsured residents in Chelan, Douglas, and Okanogan counties.	Various strategies to support providers and community members to facilitate enrollment in existing public programs and targeting resources to needs.	Various strategies to sustain community providers, expand insurance coverage, and improve clinical and patient information systems.	CAP
Inland Northwest in Charge Initiative	Health Improvement Partnership (Spokane)	Un- and underinsured residents of 11 counties in eastern Washington.	Various strategies to facilitate enrollment in existing programs and use existing funds more efficiently, including outreach, care management, etc.	Expand access to existing resources; develop effective care management systems; improve patient referral and information systems.	CAP CIC
Jamestown S'Klallam Managed Care Program	Jamestown S'Klallam Tribe	Tribes contract health service area of Clallam and Jefferson counties and the 242 Tribal members.	Provides access through purchase or subsidies of public and private health insurance.	Assure access to all Tribal members by coordinating coverage, insuring uninsured members, and providing wrap-around services.	Internal IHS Medicaid
Kids Get Care	King County Health Action Plan, Public Health-Seattle & King County	Children aged 0-5 in three communities of King County with a high concentration of un- and underinsured children.	Early screening for physical, oral, and developmental health and linking children to health care homes through local providers and community organizations	Assuring that children receive basic health care services regardless of insurance status and improving children's health status through a focus on early prevention	CAP Other grants
NorthEast Washington Medical Clinics	Colville Medical Group and Mt. Carmel Hospital	North Stevens, Pend Oreille, and Ferry counties, ~35,000 people.	Creation of a not-for-profit corporation (NE WA Medical Clinics) to integrate and manage outpatient ambulatory care.	Improve efficiency, quality, and coordination of rural health services.	Internal
100% Access Project	CHOICE Regional Health Network	93,000 residents <250% FPL in Grays Harbor, Lewis, Mason, Pacific, and Thurston counties.	Various short term survival and long term sustainable strategies, including outreach, care management, etc.	Coordinated access to uniform set of services; coordinated funding; sustainable providers.	Internal CAP WHF Other grants
Rural Health Reform Workgroup	Jefferson County Public Hospital District #2 / Jefferson County Board of	Residents of eastern Jefferson County.	Community process to identify effective strategies to maintain and improve access.	Access for all area residents and a sustainable system of health service providers.	Internal WHF

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Washington State Planning Grant on Access to Health Insurance

Summary Descriptions of Targeted Community Access Initiatives

(Excerpted from draft consultant report on Community Access Initiatives) *

Community Access Initiative	Lead Organization(s)	Scope (geographic, subpopulation, etc.)	Description	Purpose(s) and Expected Outcome(s)	Funding
	Health				
Arkansas River Valley Rural Health Cooperative	Arkansas River Valley Rural Health Cooperative (Paris, Arkansas	45,000 residents of Franklin, Logan, and Scott counties; ~6,000 non-elderly uninsured.	Planning to provide access to basic health services through local providers using a wrap- around catastrophic insurance product.	Cover 50% of non-elderly uninsured (~3,000 people).	Internal
Rural Wisconsin Health Cooperative	Rural Wisconsin Health Cooperative	28 rural acute, general hospitals and their communities in south-central and mid-state Wisconsin	Cooperative supports health organizations through management services such as credentialing and data collection, and seeks and manages grants for multiple organizations.	Advocates for rural health and supports providers through clinical/management services and managed care contracting.	Internal

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Initiatives are in a variety of developmental stages. Some community projects are still in conceptual phases –where the organizations and community leaders are involved in discussions about key issues and potential approaches to address these issues, but have not yet developed specific projects or initiatives to implement; some are in project development phases —where priorities have been set and specific projects identified; and a few are in a program implementation phase —where community initiatives have developed a series of interventions to improve access, often with a vision of how the individual projects fit together to solve multiple access problems.

Each effort offers a unique approach tailored to its community needs and resources. For example, one project represents a multi-faceted collaborative partnership that includes city and county public health, the state hospital association, health plans, hospitals, long-term care providers, community organizations, community clinics, local and state government, a university, business, labor, consumer and foundation groups. This project, the King County Action Plan, is a larger scope than many projects, perhaps paralleling the size of their community and the numbers of uninsured and underserved --King County represents the highest population base in the state.

Other projects bring equally diverse parties together, like the Colville Indian Tribe and the Grand Coulee public hospital district, in an effort to creatively address some of the health care challenges faced by this very rural North - Eastern corner of the state.

A second component of the State Planning Grant research focused on a 'needs assessment' – focus group discussions with community initiatives on their challenges, potential barriers to success, and interests in state partnership. Initial efforts were focused on identifying where the state has created barriers that could be addressed – through regulatory or statutory changes for example. Few local efforts have reached a level of development at which they could specify desired state regulatory or statutory changes. However, communities provided a range of feedback on state interactions and business approaches they would be interested in seeing modified. Suggestions range from very targeted ideas such as delegating eligibility and enrollment functions for Basic Health and Medicaid to communities, to broad suggestions for collaborative or consolidated purchasing across all state health programs.

Some of the feedback from community projects is similar in nature to the feedback received within the administrative simplification research, and when brought together for analysis and assessment, themes may begin to emerge that provide a framework for the state to re-think some processes, business approaches, and coordinated policy and planning. As mentioned previously, the initial research phase is just nearing completion, and there has not yet been opportunity for in-depth analysis and broad assessment with impacted parties.

Beyond the Research: One specific community-state collaborative that is under discussion centers around an alternative community-based coverage and purchasing pool model. Technical discussions have begun with interested community-based organizations, including the four CAP grantees and several Native American Tribes. Through the assistance and support of the State Coverage Initiatives program we will be holding a technical assistance consultation with a range of national experts, "on-the-street" community-based coverage experts, and interested local communities. Input from the technical assistance consultation will form the foundation for consideration of implementation interest and feasibility.

Other areas of interest identified in the research phase will be explored further. For example, community feedback regarding interactions with multiple state agencies mirrored the concerns

expressed in the administrative simplification research: frustration with multiple and varied perspectives expressed by state programs.

SECTION 5. CONSENSUS BUILDING STRATEGIES

Overview

The consensus building strategy has continued to evolve in response to the changing Washington environment and the progression of the grant work. However, the foundation of our strategy has remained constantly centered around:

a. Use of a state-agency based oversight panel, the parent of which is the Governor's Sub-cabinet on Health[xi], to provide guidance for our work and remind us to be creative in making the results of sophisticated research techniques accessible and relevant to daily program operations
b. Adherence to a guiding principle[xii] that speaks to a low key but broadly inclusive process, and
c. Recognition that consensus building on strategies viable in Washington will occur over the long run and through processes fed by the work of the grant but not unique to the grant (e.g., the Legislative process).

Over the course of the project the areas in which our strategy has evolved include:

a. Movement away from a large, multi-constituent advisory committee
b. Use of less formal and less structured avenues for building foundations (e.g., smaller meetings involving top executive-branch officials and industry leaders; informal discussions between the Governor's Health Policy Advisor and Legislative leadership; briefings between project staff and legislative staff; briefings between project staff and mid-level agency experts, participation in advisory groups for community initiatives)
c. Listening to all individuals who approach project staff with an interest and idea for improving the Washington health care system
d. Convening technical assistance briefings to connect national experts with Washington State program staff (e.g., State Coverage Initiatives discussion on reinsurance.)
e. Identification of partners working on related issues to create synergies and opportunities for both (e.g., linking-up with Community Access Program grantees, partnering with local foundations like the Washington Health Foundation and HumanLinks)
f. Taking advantage of existing meeting opportunities ranging from briefings of small groups, to orientations and brainstorming with local health system experts, to a work session at the state's annual Washington Health Legislative conference
g. Creation of a web-site with a feedback system accessible by all
h. Distributing informal e-mail updates to an assembled list (over 300 names) of individuals interested in the work of the grant, with links to the latest web-site developments
i. Use of ad hoc issue-specific groups rather than standing technical advisory committees, to discuss methods, resolve issues and review preliminary findings from project staff and the consultant team's work.

In response to the dynamics of the Washington environment and as we transition from the research phase of the project we expect that our process will continue to evolve.

Consensus-Building Strategies

The following provides a flavor of specific highlights in our consensus-building strategies.

a. Guidance – the Management Oversight Panel (MOP)

To provide guidance for the grant work, we established a management oversight panel (MOP). The composition of the group was based on the Governor's Sub-cabinet on Health. MOP members were selected because they represent top aides (e.g., deputies, policy and program advisors, executive directors) of Sub-cabinet members and because they are creative thinkers with significant and varied experience and knowledge with respect to health care in general and Washington history in particular. Agencies represented include:

- Department of Health (public health agency),
- Department of Social and Health Services – Medical Assistance Administration (Medicaid agency),
- Health Care Authority (Public Employees and Basic Health agency),
- Office of Financial Management (Governor's budget office),
- Governor's Policy Office (Governor's Health Policy Advisor),
- Office of the Insurance Commissioner (regulatory agency), and
- State Board of Health (public health advisory board).

Guidance provided by the MOP was critical in maintaining a link with agency policy issues and the reality of day-to-day operational challenges. Most importantly the link with the MOP helped keep the grant work relevant as the economic and fiscal challenges thrust upon Washington policy makers evolved.

b. Phase 1 – In Support of Initial Research

Various methods were used to solicit input and feedback that allowed us to refine our initial research methods and focus, and in some cases make exciting and productive connections with community partners engaged in related activities. These include:

- focus groups built into the substantive work to confirm and flesh out findings from the private payer survey (see Section 3)
- key informant interviews built into the substantive work to enhance findings on the universe of potential coverage strategies and to confirm methods for applying individual program rules (e.g., Medicaid and Basic Health eligibility criteria) to profiling and options analyses
- ad hoc issue groups and individual reviews targeted to reviewing (and evaluating) preliminary methods, draft work products, and initial findings from our consultant team's work
- collaborations on surveys being conducted by various community-based partners. For example; (a) the HumanLinks Foundation, *Washington Health Choices – Taking the Pulse of the Community*, that is pilot testing a public dialogue approach using a survey as one component to understand citizen values around health care issues. After six meetings with service groups in East King County the project reports that completion of the survey instrument "seems to be evoking the response hoped for." (The survey is available at http://www.whf.org/hl_survey.html.) and (b) the Health Improvement Partnership, *Expanded Choice*, that is conducting a survey to assess the Spokane market's receptivity to an idea for an alternative employer-based insurance model.

- Collaboration on a web-based survey of registrants for the popular Washington Health Legislative Conference – the theme of the conference was civic engagement and health system change. The survey offered an opportunity for the grant staff to efficiently gain insight from a knowledgeable and captive (albeit self-selected) audience. Questions related to the grant work asked registrants to select from a list of potential strategies for improving access to coverage the strategies they believed to be efficient and politically viable, and to identify populations for which they believed targeted interventions would be necessary. Results from the survey are included in Appendix III, Section 5.
- A web site http://www.ofm.wa.gov/accesshealth/accesshealth.htm was initially designed to provide easy access by potential bidders to our Request For Proposals for consultant assistance. As the project developed we redesigned the web site as a tool to educate, build awareness, and provide input and feedback into our work. In tandem with the web site we launched an "E-mail Alert" to an interested-party list of over 300 people (that has continued to grow). Through regular alerts we have notified these people of our grant activities, guided them to new items posted to the web site and solicited interest and feedback on our work. The web site has been an economical and efficient tool for broad and inclusive access to our work thus far. However, it is an impersonal medium for soliciting feedback and has not provided the occasion for the degree of honest and constructive input we were hoping for. On the other hand, the products on which feedback was requested have been limited, although we will be posting research findings to the web site over the coming months. We expect that the web site will continue to be a primary tool in gathering stakeholder input on our findings, but we recognize that much more could be gained from a more personal interactive dialog.

Many of these approaches (e.g., collaborations with partners, ad hoc groups and individual reviews, and web site development) are ongoing. They were supported by several efforts that occurred early in the project and which have evolved to respond to the changing Washington environment.

- Pre-dating but in anticipation of receipt of the grant, Governor Gary Locke held a summit of health care leaders to discuss a variety of health care concerns, including issues related to the uninsured;
- A brochure describing the goals and process of the grant was developed, used at various meetings, and posted to our website – early on it was updated to reflect refinements in our approach as our consultant team's work progressed. The most recent product used to provide an overview of research work is included in Appendix III, Section 5.
- A letter was sent from the Governor's Health Policy Advisor to over 100 constituent groups/individuals and to Legislative health care leadership to alert them to the work of the grant and invite their involvement --- this initial connection became the basis for building the first "interested party" list that has since grown to over 300 people. The initial list provided the basis for identifying individuals who were interested in specific aspects of the grant work and who were willing to participate in ad hoc issue groups as needed.
- A grant-specific website was developed.

c. Phase 2 – Beyond the Initial Research

Specific populations and circumstances to be targeted by potential coverage and access options are percolating from initial research findings. We anticipate that a variety of methods for continued consensus-building will occur beyond the initial research phase - to solicit broad-based input on these findings, to strengthen old and build new partnerships around coverage and simplification strategies and to identify areas where additional research is needed to refine and build on the initial grant work. Approaches planned or being considered to take the grant work beyond the initial research phase (including limited early attempts to solicit input on preliminary findings) are:

- A special work session at the December 4, 2001 Washington ealth Legislative Conference, *The State Planning Grant on Access – Can We Talk?* was designed to promote dialogue around the central themes of the grant work – i.e., which uninsured populations should take priority for improving coverage and access and which of the potential coverage strategies seem most viable, based on preliminary research findings available in late November 2001. Guidelines for the discussion and supportive background materials are included in Appendix III, Section 5. Although research findings at that stage were very limited (based on review of national literature and preliminary analysis of the 2000 Washington State Population Survey) the audience was very receptive to the interactive-style discussion approach and the experience was an extremely useful trial for soliciting stakeholder input once research findings have been solidified.
- Broad-based public input possibly through a series of regional meetings or conversations around the state and in partnership with others (e.g., State Board of Health; Washington Health Foundation) incorporating the work products of the grant.
- We have taken initial steps to become grounded in the formidable but exciting *Integrated Database* tool being developed by Arkansas. As we consider future approaches for more broadly disseminating information gathered during the grant work, the *Integrated Database* offers seemingly straightforward access to our data that would allow us to answer questions on-the-spot. Opportunities such as this to simplify communication of technically sophisticated information will merit further earnest attention.
- Partnership building, specifically extending collaborations with communities and with private sector groups that began in the research phase or build upon historically collaborative efforts. Challenges lie ahead to ensure the state is a ready partner. Fortunately, we can build upon existing models that have successfully brought diverse state agencies together around common goals. These include visionary and policy oriented groups like the MOP and the Governor's Sub-Cabinet on Health, as well as more technically focused efforts like the joint agency Reimbursement Steering Committee that has been ongoing for at least 10 years.
- Washington's Governor and independently elected Insurance Commissioner are currently exploring the formation of a jointly chaired health care council to link private and public leaders in exploring strategies to improve the health care system. The intent is that all significant players in the health system, (e.g., consumers, providers, purchasers, payers, agents, policy-makers, regulators, employers, and unions) will be at the table. We expect that the work of the grant will provide valuable input to several topics that may be considered by this potential council.

SECTION 6: LESSONS LEARNED AND RECOMMENDATIONS TO THE STATES

Regarding State Level Data:
State level data are essential for developing a comprehensive understanding of the characteristics and circumstances of state residents with and without health insurance coverage. Washington is fortunate to have a household survey that has been in place since 1998 – The Washington State Population Survey (WSPS). WSPS was conducted in 1998 and 2000 and the 2002 survey is currently being fielded. A detailed consultant review of all available data sources confirmed that the WSPS offers the most precise source of estimates about coverage in Washington as a whole and for sub-state areas. (A summary of the consultant's data review is in Section 8.) The sub-state data are essential for capturing and understanding the variation in regions and the underlying factors contributing to the numbers and distribution of uninsured in Washington – the value of sub-state data cannot be underestimated when translating data to local (e.g., Legislative) policy decisions.

Regarding the policy planning process:

a. **One year is not enough**, especially if there is a high need or desire to inform discussions and build consensus based on state-specific information. The rigorous analysis and refinement of state-specific information takes time that must be invested to ensure conversations begin with a firm foundation.

b. **Timing is critical**, especially in terms of the need to coordinate with "defining" events. Even though this project and improving access are not solely about state programs and government response, those are critical. For example, in Washington we are trying to be mindful of our Legislative session and the biennial budget building cycle. In Spring 2002, executive branch agencies begin their budget building process during which priorities and resources are aligned for the 03-05 biennium. Work during the following Legislative session, beginning January 2003, determines the final biennial budget (and thus the priorities for state dollars).

c. **Partner with others** who are working on similar and related issues. Synergies, economies of scale regarding effort, understanding differences in foci and desired outcomes, creating an early basis for future consensus building, and cross-pollination of ideas are among some of the advantages.

d. **Be disciplined and flexible**. Be disciplined and focused in conducting the substance the work (e.g., data collection and analysis) but let the process of engaging others be flexible and evolve as information and environment change.

e. **Develop guiding principles** as a means to communicate and educate, set expectations, and jump start discussions on the focus of the work. Different sets of principles, specific to various components of the project, may be helpful. For example, we developed one set of principles for our "approach to the work of the grant" and another set for signaling the breadth of our interest in options for addressing coverage and access.

f. **Build consultants into initial proposals** if their assistance is anticipated. There is precious little time in a one-year project, much of which can be eaten up by a 3-4 month competitive bid process (depending on state rules).

Regarding the presence of a neutral policy and research office:
The grant allowed Washington to create a State Planning Grant program office within the Governor's Executive Policy Office. The presence of a separate office dedicated to the neutral review of health care issues provided an open and relatively safe avenue for the sharing of ideas, suggestions, and questions for a variety of interest groups, individuals and communities, as well as state agencies. While it has been of value to have a policy and research office that is not swept into the day-to-day crises associated with operational programs (e.g., Medicaid) and political-policy advising (e.g., Legislative or Executive policy advisors), the challenge now will be in finding 'a home' for this work - finding leaders to take ownership of the work and keep it moving forward after this grant is completed.

Regarding opportunities to learn:
Sharing technical experiences and perspectives with other states has reinforced the value and importance of networking with other states and national experts to learn from their experiences. Sessions sponsored by the State Coverage Initiatives program and conferences for HRSA grantees provided several valuable opportunities for exchanging of ideas.

SECTION 7: RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

Regarding additional support in terms of surveys or other data efforts:

a. **Funding for planning, policy development, and pilot testing.** Given growing state budget deficits, states may need to look more than ever to the federal government and/or foundations to support certain planning and development activities (at least in the short run of the next 3-5 years).

b. **Support and Standardize State Level Data Collection.** Support effective monitoring of the uninsured at the state level by subsidizing and facilitating enhancement and standardization of state data collection efforts. Consider subsidizing current efforts, like the biennial Washington State Population Survey – to ensure that state specific surveys and other state-level research on the uninsured remain viable tools for informing policy discussions. Accessibility to detailed state-level data facilitates local analysis with more precision and less bias than national-level surveys can expect to offer. Although national CPS data provide a benchmark for limited comparison among states, Washington's sample does not represent the state's varied regional complexity. Translation into relevant information for Legislators and other policy makers to see their own 'neighbors' and develop or refine policy that is applicable 'on the street' is highly challenging. Standardizing of state-level data collection techniques would allow more precise national comparisons along more detailed dimensions.

c. **Increase access to federal data resources**. Allow health care researchers to access MEPS (Medical Expenditure Panel Survey) data at the individual observation level so that exploration of interactions between employers and individuals is possible. Sophisticated statistical techniques that allow researchers to uncover the underlying causes of uninsurance for example require synthetic matching of employer and employee data sources. Currently MEPS data offer the only real future potential for these analyses. As an alternative, provision of matching funds for states to conduct routine employer surveys would allow linkage with existing state population surveys.

d. **Explore opportunities to improve data collection for longitudinal and transitional analyses.** Support opportunities to build state-level sources of longitudinal and transitional data for exploration of the implications of changing life circumstances on coverage and access options and status.

Regarding additional research (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs:

a. **Indian Health Services:** Research options for maximizing funding and improving health outcomes with Indian Health Service – within Washington state this would help target critical care issues faced by 29 Federally recognized tribes. Over 27% of the Native Americans in Washington are uninsured. Enhancing IHS funding could ensure critical health care needs are fully addressed. In addition, coordination between IHS and other federal agencies (e.g., CMS) could help ensure policy goals are complementary.

b. **Affordability measures –** a Self Sufficiency Standard has been developed for nearly half of the states in the nation to provide a foundation for an alternative measure of income adequacy (as is briefly discussed in Section 3). We encourage further review of new measures such as this, with an eye towards consistent and broad application. The limitations of the Federal Poverty Level as a measure of income adequacy are well documented[xiii], and application of a more refined measure may allow a more comprehensive assessment of poverty in America that would help guide development of rational and appropriate policy.

c. **Regarding Systemic Approaches:** The research must move beyond focusing on approaches that can only address a very small portion of the access challenge. For example, a growing body of evidence indicates that voluntary employer subsidy approaches can at best target a marginal percentage of the uninsured. Despite their political appeal these marginal approaches will never ensure all Americans have access to basic health care - a systemic approach will likely be necessary. Policy leaders should help refocus research and implementation efforts towards meaningful reform.

Regarding Medicaid and SCHIP:

a. **Flexibility.** As states examine the range of coverage approaches that most efficiently and effectively address their needs, they will look to the federal government for streamlined administrative requirements and maximum flexibility. In addition to flexibility through formal Medicaid waivers, we encourage CMS to consider flexibility outside the 1115 waiver process as well. Approaches endorsed by Congress in the development of SCHIP could be more broadly applied including use of enrollment caps, benefit limits, and cost-sharing - in particular for any expansion populations (past and future expansion populations).

b. **Cost-sharing**. A variety of cost sharing approaches exist across Medicaid and SCHIP that may serve as a model for clarifying possible conflicts with regard to cost-sharing for Native Americans. Although tribal members are exempt from cost-sharing under SCHIP, Medicaid policy is not the same. Further synchronizing of policy objectives may be helpful.

c. **Pharmacy Rebates**. A study of pharmacy rebate requirements outlined in Section 1927 of the Social Security Act may be helpful to examine whether states may be more effective with other purchasing arrangements.

d. **Consider rewarding innovation and proactive efforts**, rather than designing program enhancements to purposefully exclude proactive efforts (e.g., maintenance of effort requirements). New enhancements in a range of areas including incentives for small employers to offer coverage; incentives for individuals to purchase coverage; or incentives for states to expand Medicaid or SCHIP eligibility, should be equally available to all, irrespective of the proactive efforts an entity pursued prior to the federal enhancement.

e. **Consider a model for smoothing eligibility:** Washington state has developed an eligibility structure for children that may offer an interesting model for consideration at the federal level. Washington has 'smoothed' eligibility criteria for children from ages 0 up to 19 so all ages of children qualify for some Medicaid coverage at 200% FPL. This simplification appears to offer promise for successfully enrolling all children in a family.

Regarding Medicare:

a. **Medicare Pharmacy Coverage** – Enactment of a drug benefit for Medicare beneficiaries would address some of the concerns with one of the most expensive and fastest growing areas of expenditures for states' Medicaid programs – the elderly and disabled populations. Low-income Medicare beneficiaries qualify for Medicaid wraparound services including pharmacy benefits. In addition to addressing some of the Medicaid impacts, the development of Medicare pharmacy coverage would free state resources from efforts to create a pharmaceutical coverage option for low-income seniors. Significant resources have been focused on addressing the critical needs of this constituency; however state level efforts may not be able to adequately handle this national challenge.

b. **Medicare and administrative simplification** – Explore opportunities to streamline assignment of provider identification numbers. There may be potential to reduce the time required to receive new numbers when providers move from one area to another. Feedback from local provider groups including individual practitioners and hospitals indicates provider identification numbers lay at the heart of payment barriers.

Methods:

Given the high cost of primary data collection, the expectation that a rich data reservoir was potentially available to be tapped, and the state's desire for ongoing monitoring of its population, the State Planning Grant program staff had a strong interest in finding creative ways to use existing data that would continue to be routinely collected by others. A methodical analysis of available data sources, conducted by our consultant team was key to ensuring that "mining" of data for better understanding Washington's uninsured populations and potential coverage options was soundly grounded throughout the project. A rigorous qualitative review of existing data sources by the consultant team focused on:

a. Analysis of existing national and Washington-based population and employer survey data for potential application to the grant's work. A systematic search identified those surveys warranting in-depth analysis based on their ability to provide:

   - Washington-specific and (where possible) sub-state estimates of health insurance coverage and related variables for the full civilian, non-institutionalized population
   - Washington-specific estimates of health insurance offered and related variables for private-sector employers
   - National or multi-state estimates comparable to Washington-specific household or employer populations
   - Estimates that can be trended over time.

b. Reasons for differences in estimates of the uninsured population across surveys

c. Gaps in data needed to understand Washington's uninsured population and match population profiles with analysis of strategies for improving access to coverage

d. Best strategies for using data that include approaches for addressing data gaps in the short term (for immediate application to the grant's work) and in the long term (for strengthening data resources available to Washington for ongoing monitoring.)

Progress:

a. Analysis of eight national and one Washington State-specific population-based surveys and two employer-based surveys provided the major grounding and direction for data used throughout the grant's work. Existing survey data were supplemented by proprietary data sources available to the consultant team; by data gathered in a grant-specific survey on benefit designs and costs in the current Washington marketplace; and by public program administrative data.

b. While some preliminary planning of focus groups to fill anticipated data gaps occurred, our thinking evolved beyond these initial attempts. Timing of focus groups is critical to their effectiveness in guiding our work. We need to build them around information about the uninsured, individual and market affordability, and analysis of potential options for improving access that may call for employer participation. We determined that until we

have completed assessment of our initial research findings, focus groups absent this information may be misguided and unfocused.

c. Future improvements to WSPS have been identified, and consistent with consultant findings, the recommendation to incorporate a verification question in the next survey has been incorporated in the 2002 WSPS currently in the field.

Findings:

a. Selection and analysis of existing national and Washington-based population and employer survey data.

Eight national and one Washington State-specific population-based surveys and two national employer-based surveys were selected for in-depth analysis of their usefulness in supporting the grant work.

The Washington State Population Survey (WSPS) and the Current Population Survey-March Supplement (CPS) provided the core population surveys for the analysis. Additional population-based surveys reviewed included the Behavioral Risk Factor Surveillance System (BRFSS), Community Tracking Study (CTS), Robert Wood Johnson Foundation Family Health Insurance Survey (FHIS), National Medical Expenditure Panel Survey-Household Component (MEPS-HC), National Health Interview Survey (NHIS), National Survey of American Families (NSAF), and the National Survey of Income and Program Participation (SIPP). Although other surveys provide unique insights into the problems of the uninsured, they were not reviewed in-depth because they aren't expected to be repeated on a regular basis, and they don't provide state-specific estimates for Washington.

Two large-scale employer surveys focusing on health benefits are available nationally, the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) and the RWJF Employer Health Insurance Survey (EHIS). Several proprietary employer surveys are available nationally but were not reviewed in-depth because their usefulness for in-depth Washington analyses is limited – they generally do not support state estimates, focus mostly on larger employers, and have not generally achieved high response rates. However, where these data complemented specific analyses (see Section 4, Benefits Distillation), they were a valuable additional source.

Appendix III, Section 8, provides a brief overview of the design features of each of the surveys reviewed. Additional summaries of varying analytic dimensions are included where they pay particular attention to:

- the precision of population-based survey estimates (e.g., sample size and survey design)
- the availability of local area estimates
- potential bias of population-based surveys
- survey questionnaire content (demographic and other information available for profiling Washington's uninsured population and evaluating potential coverage options), and
- linkage of information across sources.

b. Reasons for differences in estimates of the uninsured population across surveys

Estimates of the uninsured population vary across surveys as a result of many factors that have predictable and unpredictable effects. Information addressing reasons for these differences in estimates is essential in keeping the dialog focused on gaps and barriers to coverage and care. Understanding why estimates differ helps lessen mistrust and controversy over which numbers

are "correct" even though precise explanations for the differences aren't possible. This understanding is especially useful considering the regularity and increasing volume of national health policy studies and reports citing CPS estimates for Washington's population that are considerably higher than those obtained from the WSPS data. For example, the 2000 WSPS indicates that 8.3% of the population is uninsured while the 1999-2000 CPS provides a rate of 14%(http://statehealthfacts.kff.org/.)

Differences in estimates across surveys are explained in Appendix III, Section 8 (primarily excerpted from the consultant's report) and relate to interactions among a variety of factors:

Precision of survey estimates:
- Sampling considerations
- Sub-state estimates

Survey bias:
- Sample frames and population undercoverage
- Response rates
- Respondent selection
- Interview mode
- Recall bias

Survey Features:
- Variation in reporting enrollment in state-sponsored coverage
- Fluctuation of estimates (CPS) from survey to survey
- Use of verification questions
- Reference period of estimates (e.g., point-in-time vs period of time)
- Survey respondent cognitive factors (e.g., recall accuracy, level of detail in questions, survey focus)
- Treatment of survey participants who don't respond to health insurance questions
- Definition of uninsurance.

c. Gaps in data needed to understand Washington's uninsured population and match population profiles with analysis of strategies for improving access to coverage

The consultant team's analysis of existing data sources uncovered several areas in which data needed for analysis of health coverage problems and options in Washington were not available or were severely limited.

1. Cost of available coverage to the uninsured
No single population-based source of information is available on the variety and cost of coverage available to selected uninsured groups.
2. Dynamics of coverage
Limited state-specific measures of the dynamics of coverage are available, such as measures of the duration of uninsurance, COBRA eligibility, or events associated with loss of coverage and the transitions (job, income, family relationships) that potentially have bearing on changes in coverage status.

3. Reasons for uninsurance
Only limited information is available on reasons people go without coverage or businesses do not offer coverage. Data are available about perceived reasons and about family characteristics such as income and employment, and about employer characteristics (e.g., average payroll, and number of workers). However, survey-based data are not available on consumer or business owner attitudes and preferences for coverage. Likewise, information about willingness to participate in public programs or safety net programs is not collected in existing surveys.
4. Participation in new coverage models.
Survey-based information is quite strong for identifying basic coverage information, but is not available for identifying participation in innovative new models. Measures of actual or potential employer or individual participation in pooled purchasing arrangements or employer participation in government premium assistance programs are, for instance, not available in surveys.

d. Best strategies for using data.

Our consultant team's analyses of existing data sources defined the data foundation on which the bulk of the grant's work was built and established a clear baseline on which future analyses could be grounded. In spite of shortcomings, available survey data provide a rich resource for understanding Washington's uninsured population and for isolating sub-groups for whom potential targeted interventions might be most effective. Recommendations from our consultant team provided consistency throughout the grant work for using existing data and for finding creative approaches to fill gaps in those data. In addition, they provided lessons from other states' surveys that offer examples for potential improvements in Washington's future household surveys (i.e., WSPS.)

1. **The cornerstone of data for profiling Washington's uninsured and conducting preliminary analysis of potential coverage options was the Washington State Population Survey (WSPS)**. It had clear advantages, including: a large sample size; random-digit dialing sample design -which significantly reduces bias and enhances the precision of state and sub-state estimates; recent state and local area estimates; expected future continuation and timeliness (WSPS 2002 is underway); and control within the state to address evolving state needs.

2. **To develop key constructs not directly available, selected gaps in WSPS were filled by applying sophisticated technical methods.** These methods involved simple and statistical matching and regression imputation using three other surveys - the 1998 WSPS (for a measure of any period of uninsurance during the year); the 1997 RWJF FHIS (for a measure of the length of the uninsurance spell in progress); and the 1997 RWJF EHIS (for detailed information about the offer of employer health insurance and the affordability of coverage) and using administrative data from public programs. These methods are described fully in Appendix III, Section 8 and were critical in allowing the profiling of Washington's population to build on the demographic descriptions previously available.

3. **Strategies for supplementing data needs where existing data sources were insufficient followed a variety of paths.** A project-specific survey gathered information on benefit designs and costs that were supplemented by follow-up focus groups. Informant interviews gathered information on private sector administrative simplification initiatives and community-based strategies directed towards improving affordability of Washington's health care system. We anticipated that once our profiling analyses and potential options strategies were understood, follow-up focus groups would yield information in terms of understanding values, decision-drivers and areas of ambivalence --- for small employers and for targeted uninsured populations. As we review the results of our consultant team's analytic work the need and basis for future focus groups will become clear.

4. **Review of other states' surveys identified potential opportunities for future improvements in WSPS to fill data gaps and to minimize factors that result in reduced precision or increased bias in estimates.** Background for potential future improvements in WSPS is included in Appendix III, Section 8.

[i] Kaiser Family Foundation. (2002). Rising Unemployment and the Uninsured. Can be retrieved at www.kff.org

[ii] Federal poverty guidelines are a federal measure of poverty issued each year in the *Federal Register* by the **Department of Health and Human Services** (HHS). In 2000, the poverty level was defined as an income of $8,050 for the 1st member of a family plus $2,900 for each additional family member (i.e., for a family of four, the federal poverty level was $17,100.) A description of federal poverty measures is available at: http://aspe.hhs.gov/poverty/01poverty.htm. Specific federal poverty guidelines from 1982 to 2002 are available at: http://aspe.hhs.gov/poverty/figures-fed-reg.htm.

[iii] Lambrew, Jeanne. 2001. How the Slowing U.S. Economy Threatens Employer-Based Health Insurance, *The Commonwealth Fund.*

[iv] Glied, S.A. 2000. Challenges and Options for Increasing the Number of Americans with Health Insurance. *Inquiry*, 38 Summer 2000, pp. 90-105.

[v] Gabel, Jon. 1999. Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny. *Health Affairs* 18(6):62–74.

[vi] To calculate premium assumptions for the individual coverage options, analysis uses Premera Personal Prudent 'buyer Program Option 2 with a $500 deductible plan for non-smokers. This program is available in all but one county and represents a common plan design.

[vii] *Self Sufficiency Standards* have been developed by Diana Pearce for 22 states (including Washington) and 2 city/metropolitan areas. Full reports from each of these standards are available at http://www.sixstrategies.org/.

[viii] While public program expansions, per se, are not included in the consultant research, the use of public structures and funding are addressed as specific components under other policy option categories. Public subsidies of private insurance premiums are included in the discussion of *Financial Incentives to Individuals and Families*, and *Financial Incentives to Employers*. State funding (through tax credits or grants) for charity care or safety net services is considered in the discussion of *Direct Subsidies for Safety Net or Charity Care Services*.

[ix] The Supplemental Budget just passed by the Legislature authorizes 27,000 spaces for "transfer" of non-citizen adults and children currently served through state-funded Medical Assistance programs; an additional 20,000 spaces will be available to serve other uninsured low-income Washington residents.

[x] The Washington Health Legislative Conference was held in December 2001, and included participation of over 400-individuals who are interested in Washington's health system issues.

[xi] The Governor's Sub-cabinet on Health was created by Governor Gary Locke for the following purposes: (1) to develop and coordinate state health care policy and purchasing strategies, (2) as a forum for the exchange of information, and (3) as a forum to coordinate statewide efforts to provide appropriate, available, cost effective, quality health care and public health services to the citizens of Washington.

[xii] A set of principles was developed (a) to guide our approach to the work of the grant (ensuring that we and our consultants maintained common paths that were not at odds with agency perspectives and (b) to provide a framework to allow our research and development of interventions to address access to be broad and creative but grounded in the realities of the Washington context. These principles are included in Appendix III, Section 5.

[xiii] Pearce, D. (2001). *The Self Sufficiency Standard for Washington State* .Seattle, WA: University of Washington, School of Social Work.